REVISED REQUEST FOR AN INITIAL

HOME AND COMMUNITY-BASED SERVICES WAIVER (0410)

IN ACCORDANCE WITH SECTION 1915(C) OF THE SOCIAL SECURITY ACT

Submitted to the
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services

By the State of Washington
Department of Social and Health Services

Submission date: _____

Requested Effective Date: January 1, 2004

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SECTION 1915(c) WAIVER FORMAT

1. The State of Washington requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

a.____ Yes b.__X__ No

If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

a.__X__ 3 years (initial waiver)
b.____ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

a.____ Nursing facility (NF)
b.__X__ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)
c.____ Hospital
d.____ NF (served in hospital)
e.____ ICF/MR (served in hospital

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a.____ aged (age 65 and older)
b.____ disabled
c.____ aged and disabled
d.____ mentally retarded
e.____ developmentally disabled
f.__X__ mentally retarded and developmentally disabled (as defined in Washington Administrative Code [WAC] 388-825-030 [Attachment A-1] and implemented by WAC 388-825-035 [Attachment A-2]).
g.____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a.____ Waiver services are limited to the following age groups (specify):
b. ____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
c.____ Waiver services are limited to individuals who are mentally retarded or

developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d. X Other criteria. (Specify):

The individuals on this waiver require residential habilitation services or live at home but are at immediate risk of out of home placement due to one or more of the following extraordinary needs.

- **The individual has extreme and frequently occurring behavior challenges resulting in danger to health or safety or**
- **Has had 18 or more days of inpatient psychiatric care in the past 12 months or**
- **The individual lives in an ICF/MR and requests community placement or**
- **Requires daily to weekly one-on-one support, supervision and 24-hour access to trained others to meet basic health and safety needs.**

e. ____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a. ____ Yes b. X No

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a. ____ Yes b. ____ No c. X N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. ____ Yes b. X No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. ____ Yes b. X No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a.____ Case management
b.____ Homemaker
c.____ Home health aide services
d.__X__ Personal care services
e.__X__ Respite care
f.____ Adult day health
g.__X__ Habilitation
__X__ Residential habilitation
____ Day habilitation
__X__ Prevocational services
__X__ Supported employment services
____ Educational services
h.__X__ Environmental accessibility adaptations
i.__X__ Skilled nursing
j.__X__ Transportation
k.__X__ Specialized medical equipment and supplies
l.____ Chore services
m.____ Personal Emergency Response Systems
n.____ Companion services
o.____ Private duty nursing
p.____ Family training
q.____ Attendant care
r.__X__ Adult Residential Care
__X__ Adult foster care
____ Assisted living
__X__ Other Service Definition: Adult Residential Care
s.__X__ Extended State plan services (Check all that apply):
____ Physician services
____ Home health care services
__X__ Physical therapy services
__X__ Occupational therapy services
__X__ Speech, hearing and language services
____ Prescribed drugs
____ Other (specify):
t.__X__ Other services (specify):
1. Behavior Management and Consultation
2. Staff/Family Consultation and Training
3. Specialized Psychiatric Services
4. Community Access
5. Community Guide
6. Person to Person

u.____ The following services will be provided to individuals with chronic mental illness:
____ Day treatment/Partial hospitalization
____ Psychosocial rehabilitation
____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. X When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. ____ Meals furnished as part of a program of adult day health services.

c. ____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of

1984, P.L. 98-502.

a. X Yes b. ____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ____ Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of January 1, 2004 is requested.

20. The State contact person for this request is Chris Imhoff who can be reached by telephone at (360)902-8453 .

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a hoe and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____

Print Name: DENNIS BRADDOCK

Title: SECRETARY

Date: _____

APPENDIX A ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

__X__ The waiver will be operated by The Division of Developmental Disabilities, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

ATTACHMENT A-1
WAC 388-825-030

WAC 388-825-030 Eligibility for services. (1) A developmental disability is a condition which meets all of the following:

(a) A condition defined as mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition as described under WAC 388-825-030;

(b) Originates before the individual reaches eighteen years of age;

(c) Is expected to continue indefinitely; and

(d) Results in a substantial handicap.

(2) Mental retardation is a condition resulting in significantly subaverage general intellectual functioning as evidenced by:

(a) A diagnosis of mental retardation documented by a licensed psychologist or certified school psychologist; and

(b) A substantial handicap when the individual has an intelligence quotient score of more than two standard deviations below the mean using the Stanford-Binet, Wechsler, or Leiter International Performance Scale; and

(c) An intelligence quotient score which is not:

(i) Expected to improve with treatment, instruction, or skill acquisition above the established level; or

(ii) Attributable to mental illness or other psychiatric condition; and

(d) Meeting the requirements of developmental disability under subsection (1)(b) and (c) of this section.

(3) Cerebral palsy is a condition evidenced by:

(a) A diagnosis of cerebral palsy by a licensed physician; and

(b) A substantial handicap when, after forty-eight months of age:

(i) An individual needs direct physical assistance in two or more of the following activities:

(A) Eating;

(B) Dressing;

(C) Bathing;

(D) Toileting; or

(E) Mobility; or

(ii) An individual meets the requirements under subsection (6)(b) of this section; and

(c) Meeting the requirements under subsection (1)(b) and (c) of this section.

(4) Epilepsy is a condition evidenced by:

(a) A diagnosis of epilepsy by a board-eligible neurologist, including documentation the condition is chronic; and

(b) The presence of partially controlled or uncontrolled seizures; and

(c) A substantial handicap when the individual:

(i)(A) Requires the presence of another individual to monitor the individual's medication, and is certified by a physician to be at risk of serious brain damage/trauma without direct physical assistance from another individual; or

(B) In the case of individuals eighteen years of age or older only, requires the presence of another individual to monitor the individual's medication, and is unable to

ATTACHMENT A-1 CONTINUED

monitor the individual's own medication resulting in risk of medication toxicity or serious dosage side effects threatening the individual's life; or

(ii) Meets the requirements under subsection (6)(b) of this section; and

(d) Meeting the requirements under subsection (1)(b) and (c) of this section.

(5) Autism is a condition evidenced by:

(a) A specific diagnosis, by a board-eligible psychiatrist or licensed clinical psychologist, of autistic disorder, a particular diagnostic subgroup of the general diagnostic category pervasive developmental disorders; and

(b) A substantial handicap shown by:

(i) The presence of significant deficits of social and communication skills and marked restriction of activities of daily living, as determined by one or more of the following persons with at least one year's experience working with autistic individuals:

(A) Licensed psychologists;

(B) Psychiatrists;

(C) Social workers;

(D) Certified communication disorder specialists;

(E) Registered occupational therapists;

(F) Case managers;

(G) Certificated educators; and

(H) Others; or

(ii) Meeting the requirements under subsection (6)(b) of this section; and

(c) Meeting the requirements under subsection (1)(b) and (c) of this section.

(6) Another neurological or other condition closely related to mental retardation, or requiring treatment similar to that required for individuals with mental retardation is a condition evidenced by:

(a)(i) Impairment of the central nervous system as diagnosed by a licensed physician; and

(ii) A substantial handicap when, after forty-eight months of age, an individual needs direct physical assistance with two or more of the following activities:

(A) Eating;

(B) Dressing;

(C) Bathing;

(D) Toileting; or

(E) Mobility; and

(iii) An intelligence quotient score of at least one and one-half standard deviations below the mean, using the Wechsler Intelligence Scale, the Stanford-Binet, or the Leiter International Performance Scale; and

(iv) Meeting the requirements under subsection (1)(b) and (c) of this section; or

(b) A condition evidenced by:

(i) An intelligence quotient score at least one and one-half standard deviations below the mean, using the Wechsler Intelligence Scale, the Stanford-Binet, or the Leiter International Performance Scale; or

(ii) If the individual's intelligence score is higher than one and one-half standard deviations below the mean, then current or previous eligibility for participation in special

ATTACHMENT A-1 CONTINUED

education, under WAC 392-172-114 through 392-172-150, shall be demonstrated. Such participation shall not currently or at eighteen years of age be solely due to one or more of the following:

(A) Psychiatric impairment;

(B) Serious emotional/behavioral disturbance; or

(C) Orthopedic impairment; and

(iii) A substantial handicap when a standard score of more than two standard deviations below the mean in each of four domains of the adaptive behavior section of the Inventory for Client and Agency Planning (ICAP) is obtained, the domains identified as:

(A) Motor skills;

(B) Social and communication skills;
(C) Personal living skills;
(D) Community living skills; and
(iv) The ICAP is administered at least every twenty-four months; and
(v) Is not attributable to mental illness, personality and behavioral disorders, or other psychiatric conditions; and
(vi) Meets the requirements under subsection (1)(b) and (c) of this section; or
(c) A child under six years of age at risk of developmental disability, as measured by developmental assessment tools and administered by qualified professionals, showing a substantial handicap as evidenced by one of the following:
(i) A delay of at least twenty-five percent of the chronological age in one or more developmental areas between birth and twenty-four months of age; or
(ii) A delay of at least twenty-five percent of the chronological age in two or more developmental areas between twenty-five and forty-eight months of age; or
(iii) A delay of at least twenty-five percent of the chronological age in three or more developmental areas between forty-nine and seventy-two months of age; and
(iv) Such eligibility shall be subject to review at any time, but at least at thirty-six months of age and at least seventy-two months of age;
(v) Developmental areas as described in subsection (6)(c) of this section are:
(A) Fine or gross motor skills;
(B) Self-help skills;
(C) Expressive and receptive communication skills, including American sign language skills;
(D) Social skills; and
(E) Cognitive, academic, or problem-solving skills.
(vi) Qualified professionals, as described in subsection (6)(c) of this section, include, but are not limited to, the following professionals with at least one year's experience and training in the field of child development and preferably in the area of developmental disabilities:
(A) Licensed physicians;
(B) Licensed psychologists;
(C) Certified communication disorder specialists;
(D) Registered occupational therapists;
ATTACHMENT A-1 CONTINUED

(E) Licensed physical therapists;
(F) Case managers;
(G) Registered public health nurses; and
(H) Educators.
(vii) Any standardized developmental assessment tool may be used if the tool:
(I) Is reasonably reliable and valid by professional standards; and
(II) Demonstrates the information required to make a determination of the developmental delay; or
(d) A child under six years of age having a diagnosis of Down Syndrome.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-030, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.10.020. 92-04-004 (Order 3319), § 275-27-026, filed 1/23/92, effective 2/23/92. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-026, filed 2/28/89.]

ATTACHMENT A-2

WAC 388-825-035

WAC 388-825-035 Determination of eligibility. (1) The department shall determine an individual eligible for services upon application if the individual meets developmental disability criteria as defined under WAC 388-825-030.

(2) The department may require appropriate documents substantiating the presence of a developmental disability.

(3) When the department uses or requires the Wechsler Intelligence Test for the purposes of this chapter, the department may consider any standardized Wechsler Intelligence Test as a valid measure of intelligence, assuming a full scale score can be obtained.

(4) If, in the opinion of the testing psychologist, an individual is not able to complete all of the subtests necessary to achieve a full scale score on the Wechsler, the department shall make a professional judgment about the person's intellectual functioning, based upon the information available.

(5) When an applicant has a significant hearing impairment, the department may use or require the Leiter International Performance Scale to determine the individual's intelligence quotient for the purposes of WAC 388-825-030.

(6) When an applicant has a significant vision impairment, the department may use or require the Wechsler verbal intelligence quotient score as the intelligence quotient score for the purposes of WAC 388-825-030.

(7) When an Inventory for Client and Agency Planning (ICAP) is required by the department to demonstrate a substantial handicap, the department shall provide or arrange for the administration of the ICAP.

(8) The department shall determine an applicant's eligibility for services within ten working days of receipt of the completed application and supporting documents.

(9) Any documentation the department requires shall be subject to departmental review. The department may also review client eligibility at any time.

(10) The secretary or designee may authorize eligibility under subsection (1) of this section under the following conditions:

(a) To register a child under eighteen years of age who is eligible for medically intensive home care services, under the department's Title XIX Model 50 waiver program; or

(b) To eliminate the department's requirement for documentation of disability prior to eighteen years of age when:

(i) The applicant is otherwise eligible under WAC 388-825-030; and

(ii) The department and applicant are unable to obtain any documentation of disability originating prior to eighteen years of age; and

(iii) The department has determined the applicant's condition occurred prior to eighteen years of age.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-035, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-030, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-030, filed 7/18/84; Order 1143, § 275-27-030, filed 8/11/76.]

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1 DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. ___ Case Management

___ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1.___Yes 2.___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.___Yes 2.___No

___ Other Service Definition (Specify):

b.____ Homemaker:

___ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

___ Other Service Definition (Specify):

c.____ Home Health Aide services:

___ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

___ Other Service Definition (Specify):

d.__X__ Personal care services:

__X__ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

___ Payment will not be made for personal care services furnished by a member of the individual's family.

__X__ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

___ Family members who provide personal care services must meet the same standards as providers

who are unrelated to the individual.

__X__ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

___ A registered nurse, licensed to practice nursing in the State.
___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.
___ Case managers
__X__ Other (Specify):
A qualified home care agency or
The waiver recipient or the recipient's representative

3. Frequency or intensity of supervision (Check one):

___ As indicated in the plan of care
__X__ Other (Specify):
The waiver recipient or the recipient's representative will supervise the personal care provider on a day to day basis. Recipients hire, train and supervise qualified providers of the recipient's choice. Recipients are free to terminate the provider's employment and select new providers. Recipients also have the choice of receiving personal care services through a qualified agency.

4. Relationship to State plan services (Check one):

___ Personal care services are not provided under the approved State plan.
__X__ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an

extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

___ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

___ Other service definition (Specify):

e. X Respite care:

X Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

This is not a replacement for daycare while a parent or guardian is at work.

___ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

X Individual's home or place of residence
X Foster home
___ Medicaid certified Hospital
X Medicaid certified NF (state-operated)
X Medicaid certified ICF/MR (state-operated)
X Group home
___ Licensed respite care facility
x Other community care residential facility approved by the State that is not a private residence (Specify type): an Adult Residential Center; an Adult Residential Rehabilitation Center; a boarding home; an adult family home, a children's group care facility, a licensed child care setting, or other community settings i.e. camp or senior center.

___ Other service definition (Specify):

f. ___ Adult day health:

___ Services furnished 4 or more hours per day on a regularly

scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.___Yes 2.___No

___ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. X Habilitation:

__X__ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

__X__ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to

members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

___ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

__X__ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop

within one year (excluding supported employment programs).

Check one:

___ Individuals will not be compensated for prevocational services.

__X__ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

___ Educational services, which consist of special education and related services as defined in section s (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

__X__ Supported employment services, which consist of

paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

The State will require prior institutionalization in a NF or ICF/MR before a recipient is eligible for expanded habilitation services (pre-vocational, educational and supported employment).

1. __Yes 2. X No

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. X* Yes 2. ___No

*Coverage of transportation in the rate varies by provider and depends on the contract and negotiated rate.

___ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. X Environmental accessibility adaptations:

X Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the

individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

___ Other service definition (Specify):

i. X Skilled nursing:

___ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

X Other service definition (Specify): Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Also includes payment for nurse delegation services provided by a registered nurse, including the initial visit, follow-up instruction, and/or supervisory visits. Skilled nursing may be part time, intermittent or continuous.

j. X Transportation:

X Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

___ Other service definition (Specify):

k. X Specialized Medical Equipment and Supplies:

__X__ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

___ Other service definition (Specify):

l.____ Chore services:

___ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

___ Other service definition (Specify):

m.____ Personal Emergency Response Systems (PERS)

___ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is

staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

___ Other service definition (Specify):

n.___ Adult companion services:

___ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

___ Other service definition (Specify):

o.___ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):

p.___ Family training:

___ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

q.___ Attendant care services:

___ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

___ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

___ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

___ Other supervisory arrangements (Specify):

___ Other service definition (Specify):

r.__X__ Adult Residential Care (Check all that apply):

__X__ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is

furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed 6). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

___ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision
and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity

and respect.

Assisted living services may also include (Check all that apply):

___ Home health care
___ Physical therapy
___ Occupational therapy
___ Speech therapy
___ Medication administration
___ Intermittent skilled nursing services
___ Transportation specified in the plan of care
___ Periodic nursing evaluations
___ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

__X__ Other service definition (Specify): Adult Residential Care
Adult Residential Care (ARC) is provided in licensed boarding homes that provide for each resident's health, well-being and safety consistent with the resident's negotiated service agreement. Per individual service agreements, services may include: individual and group activities; assistance with arranging transportation; assistance with obtaining and maintaining functional aids and equipment; housework; laundry; self-administration of medications and treatments; therapeutic diets; cuing and providing physical assistance with bathing, eating, dressing, locomotion and toileting; provide stand-by one person assistance for transferring. Boarding homes must have the capacity to provide these basic services on both a scheduled and un-scheduled basis and provide them as needed by residents.

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

Behavior Management and Consultation:
Behavior Management & Consultation is the development and implementation of programs designed to support waiver participants to behave in ways that enhance their inclusion in the community. Multiple strategies, which include effectively relating to caregivers and other people in the waiver participant's life as well as direct interventions (i.e. training, specialized cognitive counseling) with the individual waiver participant are utilized to decrease aggressive, destructive, sexually inappropriate or other behaviors that compromise the waiver participant's ability to remain in the community.

Staff/Family Consultation and Training:
Consultation and training is provided to families supporting waiver participants and to personal care staff by nurses; physical, occupational, and speech therapists; psychologists; social workers; mental health counselors; marriage and family therapists; and other specialists.

Family consultation and training is authorized by DDD case management staff to assist families to meet specific need(s) of waiver participants as outlined in the individual's Plan of Care. Consultation and training includes direct 1:1 training related to the waiver participant's needs. Consultation and training does not include room and board or attendance at general conferences. It must be specific to the waiver participant's needs as documented in the plan of care.

Staff consultation and training is authorized by DDD case management staff to address the individual's assessed needs. Consultation and training enables direct service staff to more effectively implement individual written plans of care for specific individuals with areas of special need. Special need includes health and medication monitoring (e.g., for an individual with a seizure disorder which is regulated with medication); positioning and transfer (e.g., for an individual with cerebral palsy or quadriplegia who cannot move him/herself); basic and advanced instructional techniques (e.g., task analysis for activities of daily living, such as dental hygiene); non-aversive behavior management (e.g., for an individual who is occasionally aggressive or disruptive, one result of which might be property damage); and augmentative

communication systems (e.g., such as computer-assisted speech systems). Consultation and training does not include room and board or attendance at general conferences. It must be specific to the waiver participant's needs as documented in the plan of care.

Provider qualifications ensure that individuals meet basic minimum requirements in order to provide specific services to individuals with developmental disabilities.

Specialized psychiatric services not available under the state plan or the mental health 1915b waiver. This includes services by psychiatrists, physician assistants and Advanced Registered Nurse Practitioners who specialize in medications and treatment for people with MR/DD and mental illness, specialized psychiatric hospital diversion beds for DD clients, specialized consultation for DD providers on working with individual clients who are dually diagnosed, provision of functional assessments for individual clients and implementation of behavior support plans for DD clients.

Community Access Supports:
The provision of assistance with acquisition, maintenance, or improvement in activities of daily living, self-help, socialization and adaptive skills, which support individuals to live and participate in the community.

Community Access supports are provided in any community setting designated on the individual's plan of care. While they are separate and distinct from residential supports they may at times be delivered in an individual's home.

Community Access supports include instruction in skills an individual wishes to acquire, retain or improve that enhance competence, integration and/or maintain the individual's physical and mental skills.

Community Guide: Short-term services designed to develop creative, flexible and supportive community resources for individuals with developmental disabilities and their families or to help the person/family prepare a person-centered plan. The emphasis in this service is to increase access to informal community supports.

Person to Person: An extension of Community access, services and supports to assist participants to (1)articulate a personal vision for a desired life in the community; (2) to help the person define and

progress toward employment goals(3) locate and connect to sources of personal supports in the community that enhance the vision for a desired life. Services and supports include person centered planning, skill instruction, information and referral, physical support and one to one relationship building. Desired outcomes are: individual person centered plans, connection to sources of support in service to the person's vision and individualized employment planning.

t. X Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

___ Physician services
___ Home health care services
X Physical therapy services
X Occupational therapy services
X Speech, hearing and language services
___ Prescribed drugs
___ Other State plan services (Specify):

u.____ Services for individuals with chronic mental illness, consisting of (Check one):

___ Day treatment or other partial hospitalization services (Check one):

___ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills

of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication

management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,
b. prevocational services,
c. supported employment services, and
d. room and board.

___ Other service definition (Specify):

___ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

APPENDIX B-2 PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
1. Personal Care Services	Individual In-Home Provider (Includes permissible family members)			WAC 388-71-0510 through 0556 WAC 388-71-0580 through 05952 Individual Provider and Home Care Agency Provider Qualifications (note exemptions for parent providers in WAC 388-71-05930)
	Home Care Agency	Chapter 70.127 RCW (In-Home Services Agencies)		WAC 388-71-0510 through 0556 WAC 388-71-0580 through 05952 Individual Provider and Home Care Agency Provider Qualifications
	Home health Agency	Chapter 70.127 RCW (In-Home Services Agencies)		
2. Respite Care	Adult Family Home	Chapter 388-76 WAC (Adult family homes minimum licensing requirements)		
	Adult Residential Center (ARC)	Chapter 388-78A WAC (Boarding Homes)		

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Respite Care Continued	Adult Residential Rehabilitation Center	WAC 246-325-012 (Licensure-Adult residential rehabilitation centers and private adult treatment homes)		
	Boarding Home	Chapter 388-78A WAC (Boarding Homes)		
	Child Care Center	Chapter 388-151 WAC (School-age child care center minimum licensing requirements)		
	Children's Group Care Facility	Chapter 388-148 WAC (Licensing requirements for child foster homes, staffed residential homes, group care programs/facilities, and agencies)		
	Child placing agency*	Chapter 388-148 WAC (Licensing requirements for child foster homes, staffed residential homes, group care programs/facilities and agencies)		WAC 388-148-1060 (What services may a child placing agency provide?) * Payment is <u>not</u> for foster care, but for respite in licensed facilities
	Community Center			Contract Standards
	Senior Center			Contract Standards
	Parks and Recreation Dept.			Contract Standards

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Respite Care Continued	Day Care Center	Chapter 388-150 WAC (Minimum licensing requirements for child day care centers) Chapter388-155 WAC (Minimum licensing requirements for family child day care homes)		
	DD Certified Residential Provider	Chapter 388-820 WAC(Community residential services and support)		
	Foster Family Home	Chapter 388-148 WAC (Licensing requirements for child foster homes, staffed residential homes, group care programs/facilities and agencies)		
	Group home	Chapter 388-78A WAC (Boarding homes)	Chapter 388-820 WAC (Community residential services and support)	
	Home Care agency/ Home health Agency	Chapter 246-335 WAC Part 1. Requirements for in-home services agencies licensed to provide home health, home care, hospice, and hospice care center services.		WAC 388-71-0510 through 0556 WAC 388-71-0580 through 05952 Individual Provider and Home Care Agency Provider Qualifications

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Respite Care Continued	ICF/MR (state-operated RHC)		Chapter 388-835 WAC (ICF/MR program and reimbursement system)	
	Nursing Facility (State Operated RHC)	Chapter 18.51 RCW (Nursing Homes)	WAC 388-97-005 (Definitions [nursing homes])	
	Respite Provider (Individual provider)			388-825-260 What are qualifications for individual service providers? 388-825-266 If I want to provide respite care in my home, what is required? 388-825-270 Are there exceptions to the licensing requirement? 388-825-272 What are the minimum requirements to become an individual provider? 388-825-276 What are the required skills and abilities for this job? 388-825-284 Are providers expected to report abuse?
	Supported Living		Chapter 388-820 WAC (Community residential services and support)	
	Summer Program		Summer Camps	Contract Standards
3. Residential habilitation	Attendant Care (Agency Provider)	Chapter 388-825-268 requirements for agencies		Contract standards

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Residential Habilitation Continued	Attendant Care (Individual Provider)			388-825-260 What are qualifications for individual service providers? 388-825-266 If I want to provide respite care in my home, what is required? 388-825-270 Are there exceptions to the licensing requirement? 388-825-272 What are the minimum requirements to become an individual provider? 388-825-276 What are the required skills and abilities for this job? 388-825-284 Are providers expected to report abuse?
	Alternative Living (Individual Provider)			Chapter 388-820 WAC (Community residential services and support) 388-825-260 What are qualifications for individual service providers? 388-825-266 If I want to provide respite care in my home, what is required? 388-825-270 Are there exceptions to the licensing requirement? 388-825-272 What are the minimum requirements to become an individual provider? 388-825-276 What are the required skills and abilities for this job? 388-825-284 Are providers expected to report abuse?
	Adult Residential Center (ARC)	Chapter 388-78A WAC (Boarding Homes)		
	Adult Residential Rehabilitation Center (ARRC)	WAC 246-325-012 (Licensure – adult residential rehabilitation centers and private adult treatment homes)		

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Residential Habilitation Continued	Boarding Home	Chapter 388-78A WAC (boarding homes)		
	Child placing agency*	Chapter 388-148 WAC (Licensing requirements for child foster homes, staffed residential homes, group care programs/facilities and agencies)		WAC 388-148-1060 (What services may a child placing agency provide?) *The functions of these agencies are broader than the term Child Placing Agency implies. They are licensed to provide a variety of services to children.
	Family Foster Home	Chapter 388-148 WAC		
	Group Home	Chapter 388-78A WAC	Chapter 388-820 WAC (Community residential services and support)	
	Staffed Residential home	Chapter 388-148 WAC		
	Foster Group Care home	Chapter 388-148 WAC		
	State-operated Living Alternatives		Chapter 388-820 WAC	
	Supported living		Chapter 388-820 WAC	
4. Pre-vocational Services	Specialized Industries			Contract Standards
5. Supported Employment	Group Supported Employment			Contract Standards
	Individual Supported Employment			Contract Standards
6. Environmental Accessibility Adaptations	Contractor			Chapter 18.27 RCW (Registration of Contractor) Chapter 19.27 RCW (State Building Code)
7. Skilled Nursing	Licensed Practice Nurse Registered Nurse	Chapter 246-840 WAC (Practical and registered nursing)		
		Chapter 246-840 WAC		

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
8. Transportation	Transportation	Chapter 308-104 WAC		Chapter 308-106 WAC (Mandatory Insurance)
	Personal Care Service	Chapter 308-104 WAC		Chapter 308-106 WAC
9. Specialized medical Equipment and Supplies	Medical Equipment Supplier	Chapter 19.02 RCW (Business License Center Act)		
10. Adult Foster Care	Adult Family Home	Chapter 388-76 WAC (Adult Family Home minimum licensing requirements)		Chapter 388-110 (Contracted residential care services)
11. Adult Residential Care	Boarding Home	Chapter 388-78A WAC (Boarding homes)		Chapter 388-110 (Contracted residential care services)
12. Physical Therapy Services	Physical Therapist	Chapter 246-915 WAC (Physical Therapists)		Physical Therapy Services
13. Occupational Therapist	Chapter 246-847 WAC (Occupational Therapists)			
14. Speech, hearing and Language Services	Speech-Language Pathologist		WAC 246-828-105 (Speech-language pathology—Minimum standards of practice.)	Contract Standards
	Audiologist		WAC 246-828-095 (Audiology minimum standards of practice.)	Contract Standards
15. Behavior management and Consultation	Marriage and Family Therapist	Chapter 246-809 WAC (Licensure for mental health counselors, marriage and family therapists, and social workers)		

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
	Mental Health Counselor	Chapter 246-809 WAC	Chapter 246-810 WAC (Counselors)	
	Psychologist	Chapter 246-924 WAC		
	Registered Counselors		Chapter 246-810 WAC	
	Sex Offender Treatment Provider		Chapter 246-930 WAC (Sex Offender Treatment Provider)	
	Social Worker	Chapter 246-809 WAC		
16. Staff/Family Consultation and Training	Audiologist		WAC 246-828-095 (Audiology minimum standards of practice)	
	Licensed Practical nurse	Chapter 246-840 WAC (Practical and registered nursing)		
	Marriage and Family Therapist	Chapter 246-809 WAC (Licensure for mental health counselors, marriage and family therapists, and social workers)		
	Mental Health Counselor	Chapter 246-809 WAC	Chapter 246-810 WAC (Counselors)	
	Occupational Therapist	Chapter 246-847 WAC (Occupational Therapists)		
	Physical Therapist	Chapter 246-915 WAC (Physical Therapists)		
	Registered Counselor		Chapter 246-810 WAC	
	Registered Nurse	Chapter 246-840 WAC (Practical and Registered Nursing)		
	Sex offender Treatment Provider		Chapter 246-930 WAC (Sex Offender Treatment Provider)	

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
	Speech-Language Pathologist		WAC 246-828-105 (Speech-language pathology-minimum standards of practice)	
	Social Worker	Chapter 246-809 WAC		
17. Specialized Psychiatric Services	Advanced Registered Nurse Practitioner	Chapter 18.79.050 RCW		
	Physician Assistant	Chapter 18.71A.020 RCW		
	Psychiatrist	Chapter 18.71 RCW		
18. Community Access	Individual Provider			Contract Standards
19. Community Guide	Individual Provider			WAC 388-825-222 (who can become a community guide?)
20. Person to Person	Individual Provider			Contract Standards

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

Attachment B-2-a Client services Contract
Attachment B-2-b County Contract Boilerplate

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

Attachment B-2-a – Client Services Contract

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

CLIENT SERVICE CONTRACT

INDIVIDUAL PROVIDER

DSHS Contract Number:

Resulting From Solicitation Number:

This Contract is between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below.

Program Contract Number:

Contractor Contract Number:

CONTRACTOR NAME	CONTRACTOR DBA		
CONTRACTOR ADDRESS		CONTRACTOR STATE UNIFORM BUSINESS IDENTIFIER #	CONTRACTOR'S DSHS Index number
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR FAX	CONTRACTOR E-MAIL ADDRESS

DSHS ADMINISTRATION	DSHS DIVISION	DSHS CONTRACT CODE
HRSA	DDD	4763XP

DSHS CONTACT NAME AND TITLE	DSHS CONTACT ADDRESS	
DSHS CONTACT TELEPHONE	DSHS CONTACT FAX	DSHS CONTACT E-MAIL ADDRESS

Individual Provider Contracted Services (check the services that apply)

4764XP Respite Care
4765XP Attendant Care
4766XP Individual Alternative Living
4767XP Medicaid Personal Care (MPC)

IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? ☐ Yes ☐ No	CFDA NUMBER(S)	
CONTRACT START DATE	**CONTRACT END DATE**	CONTRACT MAXIMUM CONSIDERATION **$**

This Contract contains all of the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this Contract shall be deemed to exist or bind the parties. The parties signing below warrant that they have read and understand this Contract and have authority to enter into this Contract.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
DSHS SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

Attachment B-2-a – Client Services Contract Cont.

1. Definitions. The words and phrases listed below, as used in this Contract, shall each have the following definitions:

a. ”Assistance” means help provide to a client for the purpose of aiding him/her in the performance of tasks.

b. “Attendant Care” means ensuring the safety and well-being of clients through physical assistance and/or behavioral support for the purpose of maintaining the client in his/her family home.

c. “Authorized” means approved by a DDD case manager as evidenced by receipt of an SSPS Social Services notice.

d. “Central Contract Services” means the DSHS Office of Legal Affairs, Central Contract Services, or successor section or office.

e. “Contract” means the entire written agreement between DSHS and the Contractor, including any Exhibits, documents, and materials attached or incorporated by reference.

f. “Contracting Officer” means the Manager, or their replacement, of DSHS Central Contract Services.

g. “Contractor” means the individual or entity performing services pursuant to this Contractor and includes the Contractor’s owners, members, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted Subcontract, “Contractor” includes any Subcontractor and its owners, members, officers, directors, partners, employees, and/or agents.

h. “DDD” means the Division of Developmental Disabilities.

i. “DSHS” or “the department” or “the Department” means the State of Washington Department of Social and Health Services and its employees and authorized agents.

j. “Essential Care” means services that are deemed necessary for the safety or well-being of the client, including but not limited to services specified in the individual’s service plan (ISP).

k. “ISP” means Individual Service Plan, which is DSHS's written plan of service for clients.

Attachment B-2-a – Client Services Contract Cont.

l. "Personal Information" means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental

services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers, and any financial identifiers.

m. "Physical Assistance" means the provision of hands-on assistance on the performance of daily tasks or activities.

n. "Primary Caregiver(s)" means the parents, legal guardians or other persons who have or assume primary responsibility for the necessary care of the client.

o. "Protective Supervision" means supervision to ensure the safety and well being of a client, exclusive of those responsibilities which should be assumed by a legal guardian.

p. "RCW" means the Revised Code of Washington. All references in this Contract to RCW chapters or sections shall include any successor, amended, or replacement statute.

q. "Regulation" means any federal, state, or local regulation, rule, or ordinance.

r. "Respite Care" means temporary services provided to a developmentally disabled individual and/or the individual's family, on either an emergency or planned basis, without which the individual may need a more dependent program (WAC 275-27-020). This service allows primary caregivers periodic breaks from the continuing care needs of their son, daughter, or other relative or dependent.

s. "Respite Care (In Home)" means the provision of respite services in the residence of the client's family.

t. "Respite Care (Out of Home)" means the provision of respite services in the licensed residence of the Contractor, or in the home of a relative of specified degree.

u. "SSPS" means the Social Service Payment System.

v. "Subcontract" means any separate agreement or contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Contract.

Attachment B-2-a – Client Services Contract Cont.

w. "Transportation Services" means the process of transporting a client from one location to another.

x. "Unusual Incidents" means circumstances or events that concern a client's safety or well being. These may include, but are not limited to the following examples: an increased frequency, intensity, or duration of any medical conditions; adverse reactions to medication; severe behavioral incidents that are unlike the client's ordinary behavior; severe injury; running away; physical or verbal abuse to themselves or others, etc.

y. "WAC" means the Washington Administrative Code. All references in this Contract to WAC chapters or sections shall include any successor, amended, or replacement regulation.

2. Contractor Qualifications. The Contractor shall be eligible to provide Medicaid Title XIX services. The Medicaid program is authorized by the Social Security Act, Title XIX of Public Law 89-97, 42 CFR Chapter IV, RCW 74.09, Chapters 388-71-0500 through 388-71-0580 and 388-825-260 of the WAC.

The Contractor shall maintain all necessary license, registration, and certification as required by law.

3. Statement of Work. The Contractor shall provide the following services:

4764XP Respite Care.

a. The Contractor shall:

(1) Provide temporary services, usually as a short-term substitute caregiver, to individuals, families, or licensed caregivers who are caring for clients in their own home;

(2) Contact the client's parent(s) or primary caregiver(s) in order to make arrangements for the specific dates and times of care if the Contractor has not been contacted by the client's parent(s) or primary caregiver(s) within seven (7) days of receiving the respite care services authorization;

(3) Obtain from the parent(s) or primary care giver(s) information about the client's essential care requirements and ensure that the client's needs are met during care;

(4) Make arrangements with the parent(s) or primary care giver(s) for emergency medical treatment if necessary;

Attachment B-2-a – Client Services Contract Cont.

(5) Provide protective supervision for the client at all times the Contractor is engaged in providing services;

(6) Inform the parent(s) or primary caregiver(s) of any unusual incidents (as defined above) that may occur while providing services;

(7) Maintain copies of all Social Service Payment System (SSPS) authorizations to provide services;

(8) Complete and maintain copies of the Work Verification Record, DSHS 10-104A, for all services provided;

(9) Maintain a record of DSHS pre-authorized transportation provided and expenses incurred, including dates, locations, point-to-point mileage, purpose and receipts; and

(10) Maintain a Foster Care License, Day Care License, or Adult Family Home License as required in WAC 388-73 and 388-76, or successor replacement regulation, if care will be delivered in the home of the Contractor, unless the client and the Contractor are relatives as defined in WAC 388-70-064, or success or replacement regulation.

b. DSHS shall:

(1) Reimburse the Contractor for pre-authorized travel expenses, not to exceed current State of Washington rates, as published by the Office of

(2) Financial Management (OFM); and

(3) Reimburse the Contractor for out-of-pocket expenses as pre-authorized by DSHS.

c. **Consideration.** DSHS shall pay the Contractor for the respite care services at the DSHS published fee schedule in effect at the time that the services are rendered. Per DSHS published fee schedule, the Contractor hereby waives written notice of a legislative mandated rate increase and agrees that in such a case a revised Contract shall not be required. Payment will made on an hourly or daily basis. One day will equal eight (8) to twenty-four (24) hours of continuous service.

4765XP Attendant Care.

a. The Contractor shall:

(1) Provide physical and/or behavioral support that ensures the safety and well-being of a client in his/her family home, own home, or a licensed Adult Family Home;

Attachment B-2-a – Client Services Contract Cont.

(2) Provide physical assistance and support to the client to prevent injury to self or others;

(3) Provide physical assistance and support to the client in routine daily activities;

(4) Provide training and/or support to assist the client to live in the least restrictive environment;

(5) Make arrangements, when necessary, with the primary caregiver for emergency medical treatment;

(6) Provide client transportation to and from community resources and/or agencies when authorized by DSHS;

(7) Complete and maintain copies of the Work Verification Record, DSHS 10-104A, for all services provided.

b. DSHS shall:

(1) Reimburse the Contractor for pre-authorized travel expenses, not to exceed current State of Washington rates, as published by the Office of Financial Management (OFM); and

(2) Reimburse the Contractor for public transportation fares within the pre-authorized amount.

c. **Consideration.** DSHS shall pay the Contractor for the attendant care services at the following rate per hour: $. Subsequent rate increases will not require a revised Contract. Notification of subsequent rate increases will be made through the DSHS payment system

4766XP Individual Alternative Living.

The Contractor shall:

a. Provide community-based individualized client training, assistance and/or ongoing support to enable a client to live as independently as possible with minimal residential services;

b. Enable the client to maintain as much self-determination and personal power and choice as possible in meeting his/her own independent living needs;

c. Provide training and support in a manner appropriate to the age of the client in a typical community setting;

d. Provide one-on-one training and support in a manner appropriate to the age of the client in a typical community setting. The areas of training and support should include, as appropriate:

Attachment B-2-a – Client Services Contract Cont.

(1) Establishing a residence to include locating a residence, notification of address change, securing utilities and/or closure of accounts, deposits, landlord/tenant agreements, furnishings and food stuffs, and insurance;

(2) Personal safety and emergency procedures to include fire escape plan,

emergency numbers, first aid, burglary protection, and self-protection (involves vulnerability, assertiveness, and self-defense);

(3) Health and personal hygiene to include personal cleanliness, grooming and appropriate dress, human sexuality, and dealing with illness, injury and routine medical/dental care;

(4) Food/nutrition to include menu planning, food storage, cooking, and basic nutrition and diet;

(5) Home management to include maintenance and repairs, cleaning, laundry, using household appliances, and home safety;

(6) Money management and budgeting to include paying bills and keeping financial records; establishing and following a monthly budget; and money recognition and counting change, reconciling bank statements, and filing tax returns;

(7) Transportation to include use of public transportation or taxi, driver training and licensing, private transportation (car and bike care, etc.), traffic safety, and walking;

(8) Community resources to include making appointments, locating and using public and private agencies, non-paid and generic services (i.e., social security, physicians, vocational resources/application, etc.);

(9) Communications/basic literacy skills to include using telephone books, maps, bus schedules, newspaper advertisements, telling time, communicating thoughts and feelings, use of telephone, appropriate conversation;

(10) Shopping (food, clothing, etc.) to include planning (making lists), locating sales, comparative shopping, appropriate types of stores and departments;

(11) Leisure time to include assessing recreation facilities and activities, and planning leisure time (home and elsewhere);

(12) Behavior and interpersonal relationships to include assertiveness training, behavior management, stress management, time management, and building positive self-concepts;

Attachment B-2-a – Client Services Contract Cont.

(13) Assisting the client in transitioning from a more dependent or structured residential environment to the least restrictive residential environment; and

(14) Participating with each client, his/her case/resource manager and significant other(s) in developing, reviewing, and/or revising a written service plan for alternative living services in accordance with the

individual goals designated in the client's Individual Service Plan (ISP).

e. Provide written progress reports to each client's DDD case/resource manager as requested or at least two (2) weeks prior to the expiration of each six (6) month authorization period; and

f. Maintain a record of each client's current service plan for alternative living services for the duration of this Contract.

g. Complete and maintain copies of the Work Verification Record, DSHS 10-104A, for all services provided for the duration of this Contract.

h. **DSHS shall:**

Reimburse the Contractor for pre-authorized travel expenses, not to exceed current State of Washington rates as published by the Office of Financial Management (OFM).

i. **Consideration.** DSHS shall pay the Contractor for the individual alternative living services at the DSHS published fee schedule in effect at the time that services are rendered. Per DSHS published fee schedule, the Contractor hereby waives written notice of a legislative mandated rate increase and agrees that in such a case a revised Contract shall not be required.

4767XP Medicaid Personal Care (MPC).

The Contractor Shall:

a. Provide assistance with activities of daily living as described in the Service Plan, including needed live-in care, to clients needing such assistance to enable them to live in the least restrictive residential setting possible. Services must occur in the client's home unless the provider is a relative. Services may be provided in the community if authorized by DSHS/DDD and written into the Service Plan.

b. Complete and maintain copies of the Work Verification Record, DSHS 10-104A, for all services provided for the duration of this Contract.

c. Comply with DSHS authorized Service Plan and the WAC 388-15-202(38), or successor replacement regulation, definitions of allowable MPC tasks as follows:

(1) **"Ambulation"** means assisting the client to move around. Ambulation includes supervising the client when walking alone or with the help of a

mechanical device such as a walker if guided, assisting with difficult parts of walking such as climbing stairs, supervising the client if the client is able to propel a wheelchair if guided, pushing the wheelchair, and providing constant physical assistance to the client if totally unable to walk alone or with a mechanical device.

(2) **"Bathing"** means assisting the client to wash self. Bathing includes (1)

supervising a client able to bathe self when guided, (2) assisting a client with difficult tasks such as getting in or out of the tub or washing his/her back, or (3) completely bathing the client if totally unable to wash self.

(3) **"Body care"** means assisting the client with exercises, skin care including the application of non-prescribed ointments or lotions, or changing dry bandages or dressing when professional judgment is not required and pedicure to trim toenails and apply lotion to feet. In adult family homes or in licensed boarding homes contracting with DSHS to provide assisted living services, dressing changes using clean technique and topical ointments must be delegated by a registered nurse in accordance with WAC 246-840, or successor or replacement regulation. "Body care" excludes:

(a) Foot care for clients who are diabetic or have poor circulation; or
(b) Changing bandages or dressing when sterile procedures are required.

(4) **"Dressing"** means assistance with dressing and undressing. Dressing includes supervising and guiding client when client is dressing and undressing, assisting with difficult tasks such as tying shoes and buttoning, and completing dressing or undressing client when unable to participate in dressing or undressing self.

(5) **"Eating"** means assistance with eating. Eating includes supervising a client when the client is able to feed self if guided, assisting with difficult tasks such as cutting food or buttering bread, and feeding the client when the client is unable to feed self.

(6) **"Personal hygiene"** means assistance with care of hair, teeth, dentures, shaving, filing of nails, and other basic personal hygiene and grooming needs. Personal hygiene includes supervising the client when the client is performing the tasks, assisting the client to care for the client's own appearance, and performing grooming tasks for the client when the client is unable to care for own appearance.

(7) **"Positioning"** means assisting the client to assume a desired position. Positioning includes assistance in turning and positioning to prevent secondary disabilities, such as contractures and balance deficits or exercises to maintain the highest level of functioning which has already been attained and/or to prevent the decline in physical functional level. (Range of motion ordered as part of a physical therapy treatment is not included.)

Attachment B-2-a – Client Services Contract Cont.

(8) **"Self-medication"** means assisting the client to self-administer medications prescribed by attending physician. Self-medication includes reminding the client of when it is time to take prescribed medication, handing the medication container to the client, and opening a container.

(9) **"Toileting"** means assistance with bladder or bowel problems. Toileting includes supervising the client when the client is able to care for own toileting needs if guided, helping client to and from the bathroom, assisting with bedpan routines, diapering and lifting client on and off the toilet. Toileting may include performing routine pericolostomy catheter tasks for the client when the client is able to supervise the activities.

(10) **"Transfer"** means assistance with getting in and out of bed or wheelchair, or on and off the toilet, or in and out of the bathtub. Transfer includes supervising the client when the client is able to transfer self if guided, providing steadying, and helping the client when the client assists in own transfer. Lifting the client when the client is unable to assist in own transfer requires specialized training.

(11) **"Travel to medical services"** means accompanying or transporting the client to a physician's office or clinic in the local area to obtain a medical diagnosis or treatment.

(12) **"Essential shopping"** means assistance with shopping to meet the client's health care or nutritional needs. Limited to brief, occasional trips in the local area to shop for food, medical necessities, and household items required specifically for the health and maintenance, and well-being of the client. Essential shopping includes assisting when the client can participate in shopping and doing the shopping when the client is unable to participate.

(13) **"Meal preparation"** means assistance with preparing meals. Meal preparation includes planning meals including special diets, assisting clients able to participate in meal preparation, preparing meals for clients unable to participate, and cleaning up meals. This task may not be authorized to just plan meals or clean up after meals. The client must need assistance with actual meal preparation.

(14) **"Laundry"** means washing, drying, ironing, and mending clothes and linens used by the client or helping the client perform these tasks.

(15) **"Housework"** means performing or helping the client perform those periodic tasks required to maintain the client in a safe and healthy environment. Activities performed include such things as cleaning the kitchen and bathroom, sweeping, vacuuming, mopping, cleaning the oven, defrosting the freezer, and shoveling snow. Washing inside windows and walls is allowed, but is limited to twice a year. Assistance

with housework is limited to those areas of the home which are actually used by the client. This task is not a maid service and does not include yard care.

(16) **"Wood supply"** means splitting, stacking, or carrying wood for the client when the wood is used as the sole source of fuel for heating and/or cooking. This task is limited to splitting, stacking, or carrying wood when the wood is at the client's own home. DSHS shall not allow payment for a

provider to use a chain saw or to fell trees.

(17) **"Supervision"** means being available to:

(a) Help the client with personal care tasks that cannot be scheduled (toileting, ambulation, transfer, positioning, some medication assistance); and/or

(b) Provide protective supervision to a client who cannot be left alone because of the client's impaired judgment.

d. Successfully complete the required training per WAC 388-71-0520 through 0535, or successor or replacement regulation. **If providing services to DDD eligible adults:**

(1) Unless the Contractor is the parent provider for their own DD adult child, individual providers must successfully complete or challenge the fundamentals of caregiving training within 120 days of employment, unless he/she meets an exemption requirement listed in WAC 388-71-0525.

(2) Unless the Contractor is the parent provider for their own DD adult child, 10 hours of continuing education related to caregiving must be completed each calendar year following initial certification.

(3) Per WAC 388-71-0530, natural, step, or adoptive parents who are the individual provider for only their own adult child are exempt from the fundamentals of caregiving training if they complete a six-hour DDD approved training within 180 days of employment. These parent providers are also exempt from continuing education requirements.

(4) Per WAC 388-71-0525 designated professionals are exempt from the fundamentals of caregiving training if they complete the modified fundamentals of caregiving training within 120 days of employment.

(5) The provider shall provide DDD documentation of training upon request to verify compliance with training requirements and timelines.

(6) DSHS shall not authorize reimbursement for MPC services rendered by a care provider who does not meet the education and training requirements.

Attachment B-2-a – Client Services Contract Cont.

(7) DSHS may terminate a contract or refuse to renew a contract with a care provider who does not meet the education and training requirements.

(8) Consideration. DSHS shall pay the Contractor Medicaid personal care services at the DSHS published fee schedule in effect at the time that services are rendered. Per DSHS published fee schedule, the Contractor

hereby waives written notice of a legislative mandated rate increase and agrees that in such a case a revised Contract shall not be required.

In addition to the above statements of work(s) the follow provisions also apply to this Contract:

a. A background check/criminal history clearance is required for the contractor, and any employees, subcontractors, and/or volunteers who may have unsupervised access to vulnerable DSHS clients, in accordance with RCW 43.43.830-845 and RCW 74.15.030.

b. The Contractor shall report all instances of suspected client abuse to DSHS in accordance with state law.

c. The Contractor shall submit a written report of any unusual incident to the DDD case or resource manager within seventy-two (72) hours.

d. The Contractor shall allow DSHS and Washington Protection and Advocacy System (WPAS) access to the clients.

e. To promote a safe plan of care, DSHS does not expect a contractor to work more that 200 hours per month and retains the right to limit the hours per month authorized to a contractor.

f. The Contractor shall provide services in compliance with the department's published "Individual Provider Information Booklet."

g. The Contractor agrees to report the death of any client within twenty-four (24) hours to the client's DDD Case Manager.

h. The Contractor agrees to report to the client's DDD Case Manager within twenty-four (24) hours any significant change in the client's condition.

4. Billing and Payment.

a. DSHS shall pay the Contractor monthly for pre-authorized services provided to DSHS clients at the rate specified in the Statement of Work.

Attachment B-2-a – Client Services Contract Cont.
DSHS shall send invoices generated by SSPS to the Contractor.

b. The Contractor shall indicate on each invoice received from DSHS whether the services were delivered.

c. The Contractor shall submit the invoices for payment as

d. directed on the invoice **or** by using Invoice Express.

e. The Contractor shall contact the DSHS staff who authorized the services if there is any problem with the SSPS invoice.

f. DSHS shall use the completed SSPS invoice to generate payment to the Contractor.

g. DSHS shall not pay the Contractor for cancelled or missed appointments.

h. DSHS shall not reimburse the Contractor for authorized services not provided to clients, or for services provided which are not authorized or provided in accordance with paragraph 2, "Statement of Work." If DSHS pays the Contractor for services authorized but not provided by the Contractor in accordance with this Contract's "Statement of Work," the amount paid shall be considered to be an overpayment, and must be repaid to the department.

i. The Contractor is prohibited from collecting or accepting additional payments from any source for hours of service compensated by DSHS.

j. If this Contract is terminated for any reason, DSHS shall pay for only those services authorized and provided through the date of termination.

5. Advance Payment and Billing Limitations.

a. DSHS shall not make any payments in advance or anticipation of the delivery of services to be provided pursuant to this Contract.

b. DSHS shall pay the Contractor only for authorized services provided in accordance with this Contract. If this Contract is terminated for any reason, DSHS shall pay only for services authorized and provided through the date of termination.

c. Unless otherwise specified in this Contract, DSHS shall not pay any claims for payment for services submitted more than twelve (12) months after the calendar month in which the services were performed.

d. The Contractor shall not bill DSHS for services performed under this contract, and DSHS shall not pay the Contractor, if the Contractor has

charged or will charge the State of Washington or any other party under any other contract or agreement for the same services.

6. **Assignment.** The Contractor may not assign this Contract, or any rights or obligations contained in this Contract, to a third party.

7. **Compliance with Applicable Law.** At all times during the term of this Contract, the Contractor shall comply with all applicable federal, state, and local laws and regulations.

8. **Confidentiality.** The Contractor may only use Personal Information or other information gained by reason of this Contract for the purpose of this Contract, and shall not disclose, transfer, or sell any Personal Information or other information to any party, except by prior written consent of the person or as provided by law. The Contractor shall safeguard such information and shall return or certify destruction of the information upon Contract expiration or termination.

9. **Contractor Certification Regarding Ethics.** The Contractor certifies that the Contractor is in compliance with Chapter 42.52 RCW, Ethics in Public Service, and shall comply with Chapter 42.52 RCW throughout the term of this Contract.

10. **Contractor Not an Employee of DSHS**. For purposes of this Contract, the Contractor acknowledges that the Contractor is an independent contractor and not an officer, employee, or agent of DSHS or the State of Washington. The Contractor shall not hold the Contractor or any of the Contractor's employees out as, nor claim status as, an officer, employee, or agent of DSHS or the State of Washington. The Contractor shall not claim for the Contractor or the Contractor's employees any rights, privileges, or benefits which would accrue to an employee of the State of Washington. The Contractor shall indemnify and hold DSHS harmless from all obligations to pay or withhold federal or state taxes or contributions on behalf of the Contractor or the Contractor's employees, unless otherwise specified in this Contract.

11. **Debarment Certification**. At the request of DSHS, the Contractor shall complete the DSHS Certification regarding Federal Debarment, Suspension, Ineligibility, and Voluntary Exclusion. The certification, if any, is incorporated into this Contract by reference.

12. **Disputes.** Either party who has a dispute concerning this Contract may request a dispute resolution process. The amount of any rate set by law, regulation, or

Attachment B-2-a – Client Services Contract Cont.

DSHS policy is not disputable. A request for dispute resolution must:

a. be *received* by the Office of Financial Recovery (OFR) at Post Office Box 9501, Olympia, Washington 98507-9501 no later than twenty-eight (28) calendar days after contract expiration or termination;

b. be sent by certified mail (return receipt) or other manner that proves OFR received the request;

c. include a statement explaining the party's position; and

d. include a copy of this Contract.

13. Execution, Amendment, and Waiver. This Contract shall be binding on DSHS only upon signature by DSHS. This Contract, or any provision, may be altered, amended, or waived by a written amendment executed by both parties, except that only the Contracting Officer or the Contracting Officer's designee has authority to waive any provision of this Contract on behalf of DSHS.

14. Governing Law and Venue. This Contract shall be governed by the laws of the State of Washington. In the event of a lawsuit involving this Contract, venue shall be proper only in Thurston County, Washington.

15. Indemnification and Hold Harmless. The Contractor shall be responsible for and shall indemnify and hold DSHS harmless from all liability resulting from the acts or omissions of the Contractor.

16. Inspection; Maintenance of Records.

a. During the term of this Contract and for one (1) year following termination or expiration of this Contract, the Contractor shall give reasonable access to the Contractor, Contractor's place of business, client records, and Contractor records to DSHS and to any

b. other employee or agent of the State of Washington or the United States of America in order to monitor, audit, and evaluate the Contractor's performance and compliance with applicable laws, regulations, and this Contract.

c. During the term of this Contract and for six (6) years following termination or expiration of this Contract, the Contractor shall maintain records sufficient to:

Attachment B-2-a – Client Services Contract Cont.

(1) Document performance of all acts required by law, regulation, or this Contract;

(2) Substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance; and

(3) Demonstrate accounting procedures, practices, and records which sufficiently and properly document the Contractor's invoices to DSHS and all expenditures made by the Contractor to perform as required by this Contract.

17. Nondiscrimination. The Contractor shall comply with all applicable federal, state, and local nondiscrimination laws and regulations.

18. Notice of Overpayment. If the Contractor receives a Vendor Overpayment Notice or a letter communicating the existence of an overpayment from DSHS, the Contractor may protest the overpayment determination by requesting an adjudicative proceeding pursuant to RCW 43.20B.

19. Obligation to Ensure Health and Safety of DSHS Clients. The Contractor shall ensure the health and safety of any DSHS client for whom services are provided by the Contractor.

20. Order of Precedence. In the event of an inconsistency in this Contract, unless otherwise provided herein, the inconsistency shall be resolved by giving precedence, in the following order, to:

a. Applicable federal, state, and local law and regulations;

b. The terms and conditions contained in this Contract; and

c. Any Exhibit, document, or material attached or incorporated by reference.

21. Ownership of Material. Materials created by the Contractor and paid for by DSHS as a part of this Contract shall be owned by DSHS and shall be "works for hire" as defined by the U.S. Copyright Act of 1976. This material includes, but is not limited to: books, computer programs, documents, films, pamphlets, reports, sound reproductions, studies, surveys, tapes, and/or training materials. Material which the Contractor uses to perform this Contract, but which is not created for or paid for by DSHS, is owned by the Contractor; however, DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS.

22. Severability; Conformity. The provisions of this Contract are severable. If any provision of this Contract is held invalid by any court, that invalidity shall not affect the other provisions of this Contract and the invalid provisions shall be

considered modified to conform to existing law.

23. Single Audit Act Compliance. If the Contractor is a subrecipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133, the Contractor shall maintain records that identify all federal funds received and expended. Such funds shall be identified by the appropriate OMB Catalog of Federal Domestic Assistance Numbers. The Contractor shall make the Contractor's records available for review or audit by officials of the federal

awarding agency, the General Accounting Office, DSHS, and the Washington State Auditor's Office. The Contractor shall incorporate OMB Circular A-133 audit requirements into all contracts between the Contractor and its Subcontractors who are subrecipients. The Contractor shall comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation.

If the Contractor expends $300,000 or more in federal awards from any and/or all sources in any fiscal year beginning after June 30, 1996, the Contractor shall procure and pay for a single or program-specific audit for that year. Upon completion of each audit, the Contractor shall submit to the DSHS Contact named in this Contract the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor.

24. Subcontracting. The Contractor may not subcontract any of the contracted services.

25. Survivability. The terms and conditions contained in this Contract that by their sense and context are intended to survive the expiration or termination of this Contract shall so survive. Surviving terms include but are not limited to: Confidentiality, Disputes, Indemnification and Hold Harmless, Inspection, Maintenance of Records, Notice of Overpayment, Ownership of Material, Termination for Default, Termination and Expiration Procedure, Treatment of Assets Purchased by Contractor, and Treatment of DSHS Assets.

26. Termination Due to Change in Funding. If the funds DSHS relied upon to establish this Contract are withdrawn or reduced, or if additional or modified conditions are placed on such funding, DSHS may immediately terminate this Contract by providing written notice to the Contractor. The termination shall be effective on the date specified in the notice of termination.

Attachment B-2-a – Client Services Contract Cont.

27. Termination for Convenience. DSHS may terminate this Contract in whole or in part when it is in the best interest of DSHS by giving the Contractor at least thirty (30) calendar days' written notice. The Contractor may terminate this Contract for convenience by giving DSHS at least thirty (30) calendar days' written notice addressed to DSHS at the address listed on page 1 of this Contract.

28. Termination for Default. The Contracting Officer may terminate this Contract for default, in whole or in part, by written notice to the Contractor if DSHS has a reasonable basis to believe that the Contractor has:

a. Failed to meet or maintain any requirement for contracting with DSHS;

b. Failed to ensure the health or safety of any client for whom services are being provided under this Contract;

c. Findings of physical abuse, emotional abuse, neglect, misappropriations of funds or financial exploitation which are substantiated by the Adult Protection Services or Child Protective Services.

d. Failed to perform under, or otherwise breached, any term or condition of this Contract; and/or

e. Violated any applicable law or regulation.

If it is later determined that the Contractor was not in default, the termination shall be considered a termination for convenience.

29. Termination and Expiration Procedure. The following provisions apply if this Contract is terminated or expires:

a. The Contractor shall cease to perform any services required by this Contract as of the effective date of termination or expiration. If the Contract is terminated, the Contractor shall comply with all instructions contained in the notice of termination.

b. The Contractor shall immediately deliver to the DSHS Contact named in this Contract, or to his or her successor, all DSHS assets (property) in the Contractor's possession, including any material produced under this Contract and any Personal Information. The Contractor grants DSHS the right to enter upon the Contractor's premises for the sole purpose of recovering any DSHS property that the Contractor fails to return within ten (10) calendar days of termination or expiration of this Contract. Upon failure to return DSHS property within ten (10) calendar days, the Contractor shall be charged with all reasonable costs of recovery, including transportation. The Contractor shall protect and preserve any

Attachment B-2-a – Client Services Contract Cont.

property of DSHS that is in the possession of the Contractor.

c. DSHS may withhold a sum from the final payment to the Contractor that DSHS determines necessary to protect DSHS against loss or additional liability.

d. The rights and remedies provided to DSHS in this paragraph are in addition to any other rights and remedies provided at law, in equity, and/or under this Contract, including consequential damages and incidental damages. The Contractor may request dispute resolution as provided in this Contract.

30. Treatment of Client Assets. Unless otherwise specified in this Contract, the Contractor shall ensure that any adult client receiving services from the Contractor under this Contract has unrestricted access to the client's personal property. The Contractor shall not interfere with any adult client's ownership, possession, or use of the client's personal property. The Contractor shall provide clients under age 18 with reasonable access to their personal property that is appropriate to the client's age, development, and needs. Upon termination of this Contract, the Contractor shall immediately release to the client and/or the client's guardian or custodian all of the client's personal property.

31. Treatment of Assets Purchased by Contractor. Title to all assets (property) purchased or furnished by the Contractor is vested in the Contractor and DSHS waives all claim of ownership to such property.

32. Waiver of Default. Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default and shall not be construed to be a modification of the terms and conditions of this Contract.

APPROVED AS TO FORM BY THE OFFICE OF THE ATTORNEY GENERAL

Attachment b-2-b: County Contract Boilerplate

1. PURPOSE. The Department of Social and Health Services (DSHS), Division of Developmental Disabilities (DDD) currently contracts with the Counties within the State of Washington to provide a variety of services for the clients of DDD. Client eligibility and service referral is the responsibility of DDD pursuant to WAC 388-825-030 and 388-825-055. Only persons referred by DDD shall be eligible for services reimbursed under this contract. DSHS shall notify the County of persons authorized and referred for services. The County and the Region shall agree on how and when notification shall be given regarding people on waiting lists.

2. STATEMENT OF WORK.

a. The Contractor will furnish the services as described below and in accordance with the Contractor's Service Information Form (SIF). The SIF which contains the Contractors estimated number of people served and targeted outcomes is hereby incorporated into this Agreement by reference The funding for each service is in accordance with Exhibit A, Program Agreement Budget.

b. State Supplementary Payments (SSP): The fiscal year 2003 operating budget requires DDD to replace state general fund payments for some DDD clients with SSP. SSP payments are made directly to the DDD client. DDD determines eligibility for SSP according to the requirements in Emergency WAC 388-825.

c. SSP Oversight: Clients receiving SSP for the purchase of employment/day program services will pay the county or county subcontracted vendors for employment/day program services. The county will provide, but is not limited to, the following services:

(1) Coordination and oversight of providers and services which support clients receiving SSP employment /day program money;

(2) Information and education for SSP recipients and families about SSP, county contracted providers, contract formats and self-directed services;

(3) Certification of providers on a biennial basis;

(4) Evaluation and monitoring of employment/day program services for quality assurance.

(5) Provide monthly reporting of services funded through client SSP payments. The most common reporting system is the County Human Resource Information System (CHRIS).

3. CONSIDERATION.

a. CONVEYANCE OF THE ESTIMATED NUMBER OF PEOPLE TO BE SERVED AND TARGETED OUTCOMES. The County shall submit the Service Information Forms (SIF) of 7/1/01, provided by DDD, to indicate the estimated number of people served and targeted outcomes within the categories of Community Information Activities, Consumer Support, and Other Activities, where appropriate by September 2001. Suggestions for outcomes shall be chosen from any or all of the following documents supplied by DDD: the County Guidelines of July 1992; Service Guidelines of August 1995 for Person to Person; the Service

Attachment B-2-b: COUNTY CONTRACT BOILERPLATE CONT.

Guidelines of July 1992 for Individual and Family Assistance; and the Washington approved plan for Individuals with Disabilities Education Act (IDEA), Part C, all of which are hereby incorporated by reference. The SIF are incorporated herein by reference. Once approved the SIF outcomes may be modified only by mutual agreement of the parties.

b. APPROVAL OF FEES — DDD RESPONSIBILITY The Division, through the Regional DDD Offices, reserves the right to approve fees/rates the County pays for the service being provided by the County. The County and Region shall agree on the process to be used for fee/rate approval.

c. TRANSITION PROVISO FUNDS. Persons born between September 1, 1979 and August 1, 1981 shall be eligible for employment, or other day activities and training programs funded with Transition Proviso Funds . Individuals born between 9/1/79 and 8/31/80 become eligible for such services and such funding beginning in Fiscal Year (FY) 02. Individuals born between 9/1/80 and 8/31/81 become eligible for such services and such funding beginning in FY 03.

d. FUNDS DESIGNATED FOR ADULT DAY HEALTH CONSUMERS. Funds designated for Adult Day Health Consumers are available to clients who were served during December 1996 in Adult Day Health agencies and were subsequently determined ineligible for Levels II or III Adult Day Health. Level I services are supervised day programs where frail and disabled adults can participate in social, educational, and recreational programs. Level II and III services are licensed rehabilitation and skilled nursing services along with socialization. These clients may be referred to services defined in the BARS Manual Supplement or to an Adult Day Health service, other than Level II or III. If a client is no longer needing and wanting services, the funds are available for other clients who are not part of the original group of clients identified in December 1996. An Adult Day Health service shall only be provided by Adult Day Health agencies certified by the local Area Agency on Aging.

e. COUNTY COLLABORATION WITH DIVISION OF VOCATIONAL REHABILITATION (DVR) The County may enter into an agreement with DVR to use a portion of the County DDD General Fund-State Appropriation to match DVR federal funds.

f. SSP OVERSIGHT

(1) DDD will notify the county of the names and DDD serial numbers and the amount of SSP awarded to those DDD clients determined eligible for SSP.

(2) The consideration of this contract will be reduced by the amount of SSP awarded to each client funded under this Contract in fiscal years 2002 and 2003.

Attachment B-2-b: COUNTY CONTRACT BOILERPLATE CONT.

(3) For oversight of SSP related services, the county will be reimbursed at the same rate the county received for administrative expenses in the original 2001-2003 agreement for those clients previously covered under that agreement who are currently receiving SSP for employment/day program services.

(4) For new 2001-2003 transition clients, the county will be reimbursed up to seven per cent of the amount of the SSP received by the recipient.

(5) The reimbursement rate is dependent on available funding.

4. BILLING AND PAYMENT.

a. COUNTY PROGRAM AGREEMENT BUDGET. DSHS shall pay the County all allowable, allocable and reimbursable costs, as defined in the DDD Budget Accounting and Reporting System (BARS) Manual Supplement of 7/1/01. Reimbursement for Fiscal Year (FY) 02 and FY 03 shall not exceed the revenue for each of the FY's revenues listed in this County Program Agreement Budget. Furthermore, these payments shall not exceed (1) the County's actual reimbursable cost for the service, or (2) the amount, at the element level, in this County Program Agreement Budget, whichever is less. However, with written agreement between the two parties, the parties may increase or decrease the program agreement amount by signing a revised Program Agreement Budget. Any revised Program Agreement Budget is incorporated into this Program Agreement by reference.

b. BIENNIAL SPENDING PLAN. The County shall submit for approval a "Biennial Spending Plan" within thirty (30) days of execution of this County Program Agreement. The "Spending Plan" shall be allocated at the BARS sub-element service code level. Within 30 days of the Spending Plans submittal, the County and Region shall develop a schedule for reviewing and modifying the Spending Plan. Once approved the spending Plan may only be modified by mutual agreement of the parties.

c. COMPLIANCE WITH BARS POLICIES. The County shall take any necessary and reasonable steps to comply with the currently effective DDD BARS Supplement manual incorporated by reference herein.

d. MONTHLY INVOICES WITH DOCUMENTATION. All requests for reimbursement by the County for performance hereunder must be submitted on a DSHS A-19 invoice with attached documentation, as required in DDD County Billing and Reporting Instructions. The County may submit a combined claim to all programs/services covered by this agreement. The most common documentation is through the County Human Resource Information System (CHRIS). A claim for each individual occurs on the CHRIS documents by indicating the number of service units

delivered to each individual listed and the fee per unit. A unit is defined as:

(1) A “Contact” which is up to one (1) hour of direct service, or;

(2) An “Hour” which is at least fifty (50) minutes of direct service, or;

(3) A “Day” which is at least one (1) hour of direct service or assigned service responsibility; or

(4) A "Month" which is at least fifteen (15) days of direct service or assigned service responsibility.

(5) A “Project” which is applicable to new services that don’t easily fit into Bars codes (Individual and Family Assistance, and Person to Person). These services may be offered as projects involving an individual or a group of people.

e. TIMELINESS OF AND MODIFICATION TO BILLINGS. All initial invoices with documentation must be received by DDD within sixty (60) calendar days following the last day of the month for which the service is provided. Corrected invoices and documentation will be accepted throughout the period of this County Program Agreement. DDD agrees to operate CHRIS and produce accurate and timely reports, as needed, and to provide instruction and training to the counties on the use of the CHRIS system.

5. EVALUATION

a. COUNTY EVALUATION SYSTEM. The County shall complete and have available for review a Service Evaluation System. The evaluation system shall include the Criteria for an Evaluation System of July 1, 1999. A copy of such Service Evaluation System shall be provided upon request to the Region for review and approval.

b. COUNTY ON-SITE MONITORING. The County shall monitor services delivered to assure compliance with this County Program Agreement and conduct at least one on-site visit to each subcontractor during the period of this Program Agreement. The County shall maintain written documentation of all monitoring and on-site visits. Copies of such documentation will be provided to the Regional DDD Office upon request.

c. COUNTY REPORTS ON NUMBERS TO BE SERVED AND OUTCOMES. The County shall provide a written report to the Regional DDD Office indicating the fulfillment of the targets and estimates made concerning the Numbers of People Served and Outcomes. The frequency of the report shall be stated in the Service Information Forms. The report shall describe the reason for any shortfall concerning the estimated Numbers of People Served and Targeted Outcomes and proposed action, if needed.

6. RECOVERY OF FEES. If the contractor bills and is paid fees for services that the department later finds were (a) not delivered or (b) not delivered in accordance with applicable standards the department shall recover the fees for those services and

contractor shall fully cooperate during the recovery.

7. SUB-CONTRACTING.

a. SUBCONTRACTORS. The County shall notify the Regional DDD Office of the following: (1) the names, addresses, contact person, and telephone numbers of subcontractors and the service each will provide, and (2) the County's intent to terminate a subcontract serving a division referred client.

b. REGIONAL APPROVAL OF SUBCONTRACTORS. The Regional DDD Office shall review subcontractors and shall notify the County of any disapproval of the subcontractors identified by the County.

c. CHANGES IMPACTING SUBCONTRACTORS. The Regional DDD Office shall inform the County of an intent to modify any service program (e.g.. residential) and the residential plan and day program need of each newly identified person with day program funding.

d. INFORMATION EXCHANGE SCHEDULES AND PROCEDURES. The County and the Regional DDD Office shall develop a schedule and procedures for the information exchange concerning new subcontractors and Regional plans to modify a service program.

e. AVAILABILITY OF STATEMENTS OF WORK. Upon written request from the Regional DDD Office, the County shall provide a copy of each subcontractor's Statement of Work.

8. CREDENTIALS AND MINIMUM REQUIREMENTS

a. QUALIFIED COORDINATOR. Either by way of a County employee or by subcontract, the County agrees to provide or designate a coordinator who has training/experience in delivery of human services. The county coordinator shall not have a contract with the County to provide Training, Community Information Activities, Consumer Support, or Other Services as defined in the DDD Bars Supplement, and shall not be a board member, officer, or employee of an agency contracting with the County to provide such services. (Minimum grant counties, which deliver client services with County employees, are exempted from this provision).

b. QUALIFIED ADVISORY BOARD MEMBERS. The County, if it has an advisory board, shall include members knowledgeable about developmental disabilities. The board member shall not have a contract with the County to provide Training, Community Information Activities, Consumer Support, or Other Services as defined in the DDD Bars Supplement, and shall not be a board member, officer, or employee of an agency contracting with the County to provide such services.

c. Intermediate Care Facilities for Mentally Retarded (ICF/MR) AGREEMENT. If

applicable, the County shall assure that all county-operated or subcontracted programs serving persons living in ICF/MR implement a written agreement with the ICF/MR. The agreement shall describe how the county-operated or sub-contracted program and the ICF/MR will jointly plan and coordinate their services on behalf of the ICF/MR resident. Each agreement must also be approved and signed by the County and the DDD Regional Office with a copy kept in the DDD Regional Office.

d. ASSIGNMENT OF MEDICAID BILLING RIGHTS. The County assures that the subcontractor has agreed to assign to the County its Medicaid Billing Rights for services to DDD clients eligible under Title XIX programs. Written documentation shall be available to DSHS on request. If a subcontractor contracts directly with DSHS to provide covered services under Title XIX, the County agrees that funding intended for those clients shall be deleted from this contract.

9. SINGLE STATE MEDICAID AGENCY—DSHS. DSHS, as the single state Medicaid Agency, retains administrative authority for Title XIX coverage of services for people with developmental disabilities. The County has the responsibility for the daily operation of services covered in this agreement.

10. DUPLICATIVE FUNDING. Client services shall not be reimbursed under this County Program Agreement when the same services are paid for under the Rehabilitation Act of 1973 (DVR), P.L. 94-142 (Public Education), or are being funded under the Plan for Achieving Self Support (PASS) or Impaired Related Work Experiences (IRWE).

11. BACKGROUND / CRIMINAL HISTORY CHECK. A background criminal history clearance is obtained for all employees, subcontractors, and/or volunteers who may have unsupervised access to vulnerable DSHS clients, in accordance with RCW 43.43.830-845 and RCW 74.15-030.

12. DSHS/WPAS Access Agreement. The Washington Protection & Advocacy, Inc. (WPAS) February 27, 2001 Access Agreement with the Division of Developmental Disabilities (DDD), a true and accurate copy of which is attached hereto and incorporated herein by reference. The county assures that it and its subcontractors have reviewed the Access Agreement. The agreement covers WPAS access to individuals with developmental disabilities, clients, programs and records, outreach activities, authority to investigate allegations of abuse and neglect, other miscellaneous matters, and is binding for all providers of DDD contracted services.

Attachment B-2-b: COUNTY CONTRACT BOILERPLATE CONT.

EXHIBIT A
2001-2003
Program Agreement Budget

Agreed budget between County/Counties and the Division of Developmental Disabilities for Contract Number:

☐ **Original Budget** ☐ **Budget Revision**

REVENUES

Fiscal Year	Code			Title	Original	1st Revision	2nd Revision	3rd Revision
2002	334	04	68	DDD grant in aid				
2003	334	04	68	DDD grant in aid				
				Total				

EXPENDITURES

Account Titles		Original	1st Revision	2nd Revision	3rd Revision
0.10	Administration				
0.30	Training				
0.40	Community Info. Activities				
0.60	Consumer Support				
0.90	Other Activities				
TOTAL					

COUNTY SIGNATURE (S)_____DATE _____

DSHS SIGNATURE (S)_____ DATE _____

EFFECTIVE DATE _____REASON_____

APPENDIX B-3 keys standards/board and care facilities

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

___ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

__X__ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

SECTION 1915(c) WAIVER FORMAT

APPENDIX C Eligibility and Post-Eligibility

APPENDIX C-1 Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1.____ AFDC recipients
2.__X__ SSI recipients (SSI Rules States and 1634 States).
3.____ Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4.____ Optional State supplement recipients
5.____ Optional categorically needy aged and disabled who have income at (Check one):

a.____ 100% of the Federal poverty level (FPL)

b.____% Percent of FPL which is lower than 100%.

6.__X__ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Check one:

a.____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b.__X__ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)__X__ A special income level equal to:

__X__ 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR

435.236)

$\underline{\$\quad}$ which is lower than 300%

(2)___Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___Medically needy without spend down in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___Medically needy without spend down in 209(b) States. (42 CFR 435.330)

(5)___Aged and disabled who have income at:

a.____ 100% of the FPL

b.___% which is lower than 100%.

(6)___All other mandatory and optional groups under the plan are included.

(7)___Other (Include statutory reference only to reflect additional groups included under the State plan.)

Spousal impoverishment rules are used in determining eligibility for this special home and community-based waiver group at 42 CFR 435.217.

7.____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8.____ All other mandatory and optional groups under the plan are included.

9.____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

APPENDIX C-2 Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and needed home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options with regard to the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR 435.726 and 435.735 just as it does for other individuals found eligible under 435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under 1924.

REGULAR POST-ELIGIBILITY RULES--435.726 and 435.735

o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC eligibility standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of 1924 of the Act (protection against spousal impoverishment) instead of the rules under 42 CFR 435.726 and 435.735. The 1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance "which is reasonable in amount for clothes and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month, but must be a reasonable amount for clothing and other personal needs of an individual while in an institution. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. Therefore, the $30 PNA may not be a reasonable amount when the waiver recipient is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal rule may use as the personal needs allowance the maintenance amount which the State has elected for home and community-based services waiver participants who do not have community spouses.

NOTE: If the State elects to use the institutional PNA, it must demonstrate that this is a reasonable amount to cover the cost of the individual's maintenance needs in the community (see OPTION 2).

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. . **435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

i. individual: (Check one):

a.___ The following standard included under the State plan (check one):

(1)___SSI
(2)___Medically needy
(3)___The special income level for the institutionalized
(4)___The following percent of the Federal poverty level):___%
(5)___Other (specify):

B.___ The following dollar amount:
$___*

* If this amount changes, this item will be revised.

C. X The following formula is used to determine the needs allowance:

The State will apply the following maintenance allowance:

a. An allowance for waiver recipients that is no less than the SSI federal benefit rate for an individual and no greater than three hundred percent (300%) of the SSI federal benefit rate. The allowance is based on:

1.) A standard amount for client personal

and incidental needs (the CPI). The applicable state CPI amount is presently $38.84 per month, and is adjusted periodically for inflation;

2.) An amount equal to the actual estimated room and board cost for the residence in which the recipient lives;

3.) An amount equal to the first $20 of the recipient's unearned or earned income [as provided for SSI recipients at 20 C.F.R. 416.1124(c)(12)];

4.) An amount for employed individuals equal to the first $65 of the recipient's earned income, if any [as provided for SSI recipients at 20 C.F.R. 416.1112(c)(4)] plus one-half of any remaining earned income [as provided for SSI recipients at 20 C.F.R. 416.1112(c)(6)];

except that no recipient shall be allowed an individual maintenance needs deduction of less than the SSI payment standard.

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

ii. spouse only (check one):

A.___ SSI standard
B.___ Optional State supplement standard
C._X_ Medically needy income standard
D.___ The following dollar amount: $_____*
*If this amount changes, this item will be revised.
E.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.
F.___ The amount is determined using the following formula:
G.___ Not applicable (N/A)

iii. Family (check one):

A.___ AFDC need standard
B.___ AFDC payment standard

C. X Medically needy income standard
D. ___ The following dollar amount: $ ____*
*If this amount changes, this item will be revised.
E. ___ The following percentage of the following standard that is not greater than the standards above: % ___ of ____ standard.
F. ___ The amount is determined using the following formula:
G. ___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

2. ____209(b) State, a State that is using more restrictive eligibility requirements than SSI.

a. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

i. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(A) Allowances for the needs of the

(1) individual: (check one):

a.___ The following standard included under the State plan (check one):

(1)___SSI
(2)___ Medically needy
(3)___The special income level for the institutionalized
(4)___ The following percentage of the Federal poverty level:_____%
(5)___ Other (specify):

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 435.217, **enter NA in items 2. and 3**. following.

2.spouse only (check one):

A.___ The following standard under 42 CFR 435.121:
B.___ The medically needy income standard_____;

C.___ The following dollar amount:$_____*
*If this amount changes, this item will be revised.
D.___ The following percentage of the following standard that is not greater than the standards above:_____% of ____.

E.___ The following formula is used to determine the amount:
F.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard
B.___ AFDC payment standard
C.___ Medically needy income standard
D.___ The following dollar amount: $_____*
*If this amount changes, this item will be revised.
E.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.
F.___ The following formula is used to determine the amount:
G. Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2.____ The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution towards the cost of home and community-based care if it determines the individual's eligibility under 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowance for personal needs of the individual: (check one)

(i)__Institutional PNA: Specify the amount:$___*

*Explain why you believe this amount is reasonable to meet the maintenance needs of the individual in the community:

(ii)____An amount which is comparable to the amount used as the maintenance allowance of the individual for home and community based waiver recipients who have no community spouses. (check one):

(a)___SSI Standard
(b)___Medically Needy Standard
(c)___The special income level for the institutionalized
(d)___The following percent of the Federal poverty level:____%
(e)___(spouse)Other (specify):
(f)___ The following dollar amount $___**
**If this amount changes, this item will be revised.
(g)___ The following formula is used to determine the needs allowance:

APPENDIX D ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1 evaluations/level of care

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team
___ Physician (M.D. or D.O.)
___ Registered Nurse, licensed in the State
___ Licensed Social Worker
___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
_X_ Other (Specify): DDD Case/Resource Manager or Social Worker (See attached job specifications); Nursing Care Consultant; QMRP.

APPENDIX D-2 reevaluations/level of care

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months
___ Every 6 months
_X_ Every 12 months
___ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

_X_ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)
___ Registered Nurse, licensed in the State
___ Licensed Social Worker
___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
___ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

_X_ "Tickler" file
___ Edits in computer system
_X_ Component part of case management
___ Other (Specify):

APPENDIX D-3 maintenance of records

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

___ By the Medicaid agency in its central office
___ By the Medicaid agency in district/local offices
__X__ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program
__X__ By the case managers
__X__ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
___ By service providers
___ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

__X__ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

ATTACHMENT D-3-a

PROCESS AND CRITERIA USED TO ESTABLISH THE NEED FOR
THE LEVEL OF CARE PROVIDED IN AN ICF/MR

Attachment D-3-a-1 is an example of the form used to certify the need for the level of care provided in an ICF/MR for placement on the waiver. The individual who completes the evaluation verifying that the client meets the waiver level of care requirement signs this form.

The process used to evaluate (and reevaluate) applicants' need for ICF/MR level of care is two-stage consisting of:

(1) Assessment of the individual's need for support; and

(2) Review and certification by a DDD case/resource manager or Social Worker.

Protocols for Determination of the Need for ICF/MR Level of Care

An employee of the Division of Developmental Disabilities who is a case/resource manager or a social worker makes determination/verification of the need for ICF/MR level of care. Job specifications for these job classes are included as Attachments D-3-b and D-3-c.

When making the assessment of the need for ICF/MR level of care, the case/resource manager or social worker assesses the applicant's healthcare needs, and physical, intellectual and behavioral functioning, as indicated by the assessment protocol and as reflected in other information (e.g., the individual service plan) as necessary.

Scoring of the needs assessments and/or information from other available supporting information (e.g., the individual service plan, psychological evaluations, and other professional and medical evaluations) enables staff to identify the variety of individuals who require an ICF/MR level of care. This includes: 1) individuals who have low levels of cognitive functioning and require support and/or training in a variety of areas, such as activities of daily living and interpersonal relations; 2) individuals (e.g. with cerebral palsy) who have high levels of cognitive functioning and require support and/or training in areas such as medical needs, activities of daily living, and community integration; 3) individuals (e.g., with poor impulse control and/or judgment due to neurological impairment, sometimes in combination with a diagnosis of mental illness) who have varying levels of cognitive functioning, may require little support with activities of daily living, but need a high degree of support, supervision, and/or training due to behaviors that put themselves and/or others at risk, and 4) individuals who may require assistance with activities of daily living, may have varying levels of cognitive functioning, require extensive support to develop and maintain support systems, and require extensive support to work.

ATTACHMENT D-3-a
(CONTINUED)

PROCESS AND CRITERIA USED TO ESTABLISH THE NEED FOR
THE LEVEL OF CARE PROVIDED IN AN ICF/MR

Assessment-Current Support Needs

Two versions of the Assessment-Current Support Needs protocol are used in the determination of the need for ICF/MR level of care process. One is for children (ages 0 - 12) and the other is for both adolescents (ages 13 - 18) and adults (age 18 +).

Copies of the Child's Assessment-Current Support Needs (Attachment D-3-a-3) and the Assessment-Current Support Needs used for adolescents and adults (Attachment D-3-a-4) reflect the scoring of these protocols for determination of the need for ICF/MR level of care.

For children, the protocol should reflect a need for support to the left of the double vertical line (i.e., at the 'A' or 'B' level except for item # 9) or the following nine items: 1, 2, 3, 4, 5, 7, 8, 9, and 10. Children from birth through age 5 must have five of nine to the left of the double vertical line. Children ages 6 - 12 must have seven of nine to the left of the double vertical line. Fewer items are required for young children because some of the items (e.g., 1, 2, 3, 7) either do not apply to them (# 7) or do not differentiate among them (e.g., all young children require assistance with tasks such as dressing toileting and eating). If the score received does not meet the criteria listed above, other available supporting information (e.g., the individual service plan, psychological evaluations, and other professional and medical evaluations) may be reviewed to determine whether the individual requires ICF/MR level of care.

For adolescents (age 13 and above) and adults, the score across the 20 items should total at least 40. The scoring is indicated above the alternatives for each item. If the score is not at least 40, other available supporting information (e.g., the individual service plan, psychological evaluations, and other professional and medical evaluations) may be reviewed to determine whether the individual requires ICF/MR level of care.

Differential points are assigned to items on the adolescent/adult assessment to reflect the varying support, supervision, and training needs of individuals who require an ICF/MR level of care. The items that reflect the need for support to maintain health and safety (e.g., items 1, 3, 20), to work (item 14), and to deal with behavior problems (item 19), as well as the availability of others to provide support (e.g., item 15) are scored
higher than items that reflect the need for support with activities of daily living (e.g., items 4 through 8), relating to specific individuals (e.g., items 11, 12), and participation in the community (e.g., items 10, 17, 12).

If the case/resource manager or social worker determines from the assessment and/or other available supporting information (e.g., the individual service plan, psychological evaluations, social work evaluations, nursing evaluations, speech and hearing screenings, and/or other professional evaluations as necessary) that the applicant requires an ICF/MR level of care, s/he documents this determination using a form (e.g., Attachment D-3-a-2) that is included in the official client record.

DDD quality control staff will conduct ongoing reviews of eligibility determinations to ensure consistency and accuracy.

ATTACHMENT D-3-a
(CONTINUED)

If the case/resource manager or social worker concludes that the applicant does not require the level of care provided in an ICF/MR, then the individual is not placed on the Waiver. This determination is also documented with Attachment D-3-a-2. A supervisor reviews all determinations of ineligibility (i.e., due to not requiring ICF/MR level of care) to ensure consistency and accuracy.

Process for those seeking ICF/MR admission
The form for determining level of care is the same for those seeking either community-based services or admission to an ICF/MR. The form for adolescents and adults is Assessment – Current Support Needs (Adolescent to Adult). The form for children is Child's Assessment – Current Support Needs. The qualifying scores are identical for either HCBS or ICF/MR admission.

Personal care needs for either HCBS or ICF/MR admission may be assessed using the Comprehensive assessment reporting and evaluation tool (CARE).

People who request ICF/MR admission are informed of available community services and resources and are offered assistance to implement a safe community-based care plan. If ICF/MR placement is denied, the person and his/her legal representative is notified in writing of the decision and given information about appeal rights. A form for requesting a fair hearing is enclosed with the written notification.

INDEX TO ATTACHMENTS
REGARDING THE LEVEL OF CARE DETERMINATION

ATTACHMENT D-3-a-1 WAIVER ELIGIBILITY NOTIFICATION

ATTACHMENT D-3-a-2 CHILD'S ASSESSMENT - CURRENT SUPPORT NEEDS

ATTACHMENT D-3-a-3 ASSESSMENT - CURRENT SUPPORT NEEDS

ATTACHMENT D-3-a-4 COMPREHENSIVE ASSESSMENT, REPORTING AND EVALUATION (CARE) TOOL

ATTACHMENT D-3-b CASE/RESOURCE MANAGER JOB SPECIFICATIONS

ATTACHMENT D-3-c SOCIAL WORKER JOB SPECIFICATIONS

ATTACHMENT D-3-A-1

Washington State Department of Social & Health Services

DIVISION OF DEVELOPMENTAL DISABILITIES

WAIVER ELIGIBILITY NOTIFICATION

Completion of this form is required for all waiver referrals. It must be completed and forwarded to DDD Central Office, ATTN: Waiver Coordinator, Mail Stop: 45310, Olympia WA 98504-5310, as soon as all steps in the eligibility process are completed.

CLIENT DATA

CLIENT'S NAME	DDD NUMBER	REFERRAL DATE	REGION

TASK COMPLETION DATES

	ELIGIBLE IS	ELIGIBLE IS NOT
1. NCC/QMRP review completed on (date): _____	☐	☐
2. Disabled according to SSI criteria (select one of the following):		
a. Effective date as determined by the DDDS: _____	☐	☐
b. Currently receiving SSI	☐	☐
c. Currently receiving SSA as a disabled adult child	☐	☐
3. Financial eligibility effective date: _____	☐	☐
4. Individual Service Plan (ISP) completion date: _____	☐	☐
5. SSPS/CHRIS entry date: _____	☐	☐
6. Client choice form signed on (date): _____	☐	☐

A review of needs and eligibility criteria listed above indicates this individual: ☐ is eligible. ☐ is not eligible.

OPTION SELECTED BY THE CLIENT

ICF/MR ☐ Has been referred to _____ ICF/MR on _____, 20____

WAIVER ☐

CASE MANAGER	DATE	TELEPHONE NUMBER (INCLUDE AREA CODE)

ATTACHMENT d-3-a-2

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

CHILD'S ASSESSMENT - CURRENT SUPPORT NEEDS

(For children birth through age 12)

Case Manager's Key: Use with Child's Individual Service Plan, DSHS 15-170.

NAME	DATE

Waiver eligibility requirements:

- Children birth through age five (5) must have five (5) of nine (9) left of the line items designated with an "*"
- Children birth age six (6) through twelve (12) must have seven (7) of nine (9) left of the line items designated with an "*"

*** 1. What supports does the child need to dress and groom self as is expected of others of same age?**

☐ A	☐ B	☐ C	☐ D
Needs major support in the form of total physical assistance, intensive training and/or therapy for dressing and grooming self.	Needs moderate support in the form of some physical assistance and/or training and/or therapies to dress and groom self.	Needs reminders or prompts to dress and groom self appropriately.	At age level (may have physical supports) in dressing and grooming self.

*** 2. What supports does the child need to toilet self as is expected of others of same age?**

☐ A	☐ B	☐ C	☐ D	☐ E
Needs major support in the form of total physical support. Intensive training intervention and/or daily therapy to toilet self.	Needs moderate support in the form of some physical assistance, standard training and/or regular therapy.	Needs reminders or prompts.	Toilets self or has physical support in place to toilet self.	At age level.

*** 3. What supports does the child need to eat at age level?**

☐ A	☐ B	☐ C	☐ D
Needs major support in the form of total physical assistance, intensive training and/or daily therapy.	Needs moderate support in the form of some physical assistance, standard training and/or regular therapy.	Needs help with manners and appearance when eating, in the form of reminders and prompts.	At age level (may have physical supports) in eating.

*** 4. What supports does the child need to move around in the same ways as other children of same age?**

☐ A	☐ B	☐ C	☐ D	☐ E
Needs major intervention in the form of total physical support to move around, intensive training and/or daily therapy.	Needs moderate support such as someone's help to move around or may use or learn to use adaptive device or may require standard training.	Needs mild intervention in the form of training and physically prompting scooting/crawling/ walking behaviors.	Needs to be encouraged to scoot/crawl/walk.	No supports needed - child is scooting/ crawling/walking at age level.

*** 5. What supports does the child need to communicate as others of same age?**

☐ A	☐ B	☐ C	☐ D
Currently someone else must always determine and communicate child's needs.	With intensive training or therapy support, child may learn sufficient verbal and/or signing skills to make self easily understandable to others.	With physical support (adaptive device, interpreter), child is always able to communicate.	No supports needed and/or at age level.

6. What supports does the child need to learn about and use money?

☐ A	☐ B	☐ C	☐ D	☐ E
Child is not old enough to know about money.	Family must devise special opportunities for child to earn/or spend money.	Needs to learn about earning and/or spending money in typical age-level ways.	Needs prompt and/or reminders in completing tasks/transactions related to earning/ spending money.	Needs no support. Independently uses opportunities typical to his/her age group to earn and/or spend money.

*** 7. What supports does the child need to make choices and take responsibility?**

☐ A	☐ B	☐ C	☐ D	☐ E
Needs major support in the form of special and/or technical help to and from family/teachers to create opportunities for making choices and taking responsibility.	Needs moderate support in the form of family/ teachers creating and explaining a variety of opportunities for making choices and taking responsibility.	Needs some support in the form of explanation of available options for making choices and taking responsibility.	Needs no support. Readily uses a variety of opportunities to indicate choices (activity, food, etc.) and take responsibility for (tasks, self, etc.)	Child not old enough to make choice.

*** 8. What supports does the child need to explore environment?**

☐ A	☐ B	☐ C	☐ D
Needs major support in the form of specialized technical help to and from family/teachers to create ways which support/encourage child to explore and reach out.	Needs moderate support in the form of some training/physical help to and from family and teachers to create ways and opportunities for child to explore environmental and reach out.	Needs some support in the form of verbal encouragement or presence of someone child trusts to explore environment and reach out.	Needs no support and/or is at age level. Readily explores environment (may have adaptive device) and reaches out in ways typical to child's age group.

*** 9. What supports are necessary to get child's therapy health needs met?**

☐ A	☐ B	☐ C	☐ D	☐ E
Child requires medical/ health intervention or monitoring by professionals at least daily.	Child needs regular (weekly, monthly) monitoring by health professionals.	Child needs daily support and/or monitoring by trained others.	Needs regular on-going therapy and/or monitoring of health needs through typical community health systems.	No specialized supports necessary. Child's therapy and health needs are met through typical community health systems.

*** 10. What support services should the system provide to help family continue to meet child's needs?**

☐ A	☐ B	☐ C	☐ D	☐ E
Substantial significant supports to child and parents needed. Child in, or at risk of, out-of-home placement at this time.	Substantial support needed/requested; e.g., requests for more than two days per month respite, referral to homemakers, homebuilders; request for long term behavior management training, need extensive and/or expensive environmental modification or equipment; request frequent contact with case manager.	Moderate external support needed/ requested; e.g., requests for regular respite, intensive but short-term behavior management, referral for parent training help, referral to day care services; and/or request for regular contact with case manager.	Minimal external support needed/requested; e.g., requests for occasional respite, referrals to parent support group, and/or case manager helps obtain adaptive equipment.	No external supports are necessary. Family has obtained any necessary adaptive equipment.

11. What supports does the child need to make the kind of relationships with family members expected of non-disabled children of the same age?

☐ A	☐ B	☐ C	☐ D	☐ E
Opportunities for contributing to family life totally dependent on others to maintain, interpret child's role to other family members.	Requires major support in the form of daily/weekly creation of opportunities to be seen as a contributing member and assume typical family responsibilities.	Requires moderate support in the form of adaptive device, training and/or reminders to be seen as contributing member and assume typical family responsibilities.	Needs minor support in seeing self and being seen as a contributing member of the family and assuming typical family responsibilities.	Needs no support to form positive family relationship.

12. What support does the child need to explore and use typical community resources such as stores, parks, and playgrounds?

☐ A	☐ B	☐ C	☐ D
Family needs major support (perhaps respite) to continue to provide child total physical support to use typical resources.	Moderate support is needed - family must create ways for child to use these resources in ways typical to child's age group.	Minimal support needed - family may wish suggestions or some support on ways to enable child's regular use of typical resources.	Needs no support and/or at age level. Uses these resources regularly.

13. What supports are needed for the child to develop age-level skills in playing with others?

☐ A	☐ B	☐ C	☐ D
Major support needed by others to help child play. Parents may request special adaptive equipment and training to foster child's playing skills.	Moderate support needed in the form of a verbal and/or some physical intervention to help child play. Parents may be requesting suggestions instruction in ways to help child develop playing skills.	Minimal support needed.	No supports needed and/or at age level. Child's playing skills developing at age level.

14. What support does the child need to have opportunities to play with non-handicapped children?			
☐ **A**	☐ **B**	☐ **C**	☐ **D**
Substantial system support; e.g., system must set up "programs" that allow for interaction with non-handicapped children and the "programs".	Moderate supports; e.g., parents have to create opportunities for contacts. parents may ask for instruction in how to facilitate such contacts. System may need to provide structural supports; e.g., transportation, barrier-free public play environments, etc.	Minimal support; e.g., some monitoring. Parents may request help on how to broaden child's range of contacts or to increase the age appropriateness of contacts.	No support needed.

CASE/RESOURCE MANAGER'S SIGNATURE	DATE

ATTACHMENT D-3-a-3

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

ASSESSMENT - CURRENT SUPPORT NEEDS

(Age 13 and older)

NAME	SOCIAL SECURITY NUMBER	DDD NUMBER

SCORES — **AGE-LEVEL RESIDENCE (OUTCOME)**

___ 1. What supports does the person need to identify and respond safely to emergencies?

☐ **25**	☐ **16**	☐ **9**	☐ **4**	☐ **0**
Needs total physical support to respond to emergencies.	Needs help all of the time to identify emergencies and to respond.	Needs help some of the time to identify emergencies and to respond.	Independently identifies emergencies; needs help from others to respond.	Needs no help from others in emergencies.

___ 2. Are people other than care providers available for this person to seek help from at any time?

☐ **5**	☐ **4**	☐ **3**	☐ **0**
Has only care providers available.	Has someone available some of the time.	Has someone available most of the time.	Has someone available all of the time.

___ 3. What support does the person need to practice age-level safety measures?

☐ **25**	☐ **16**	☐ **9**	☐ **4**	☐ **0**
Needs total physical support for safety measures in daily activities and routines.	Does not recognize own safety needs and requires help in most safety areas.	Knows importance of safety measures. Needs training and/ or physical support in many areas.	Needs reminders or specific training in one or two safety areas.	Needs no support in providing for own safety.

___ 4. What support does the person need to toilet self as is expected of others in his/her age group?

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **0**
Needs total physical support to toilet self.	Indicates need but needs some physical support to toilet self.	Needs training to toilet self.	Needs reminders.	Needs no support. Toilets self.

___ 5. What support does the person need to dress and groom self as is expected of others in his/her age group?

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **0**
Needs total physical assistance for dressing and grooming self.	Needs training in dressing and grooming self.	Needs reminders to dress and groom self appropriately.	Needs help with appearance and recognizing styles.	Needs no support. At age level in dressing and grooming self.

___ 6. What support does the person need to eat at age-level?

☐ **5**	☐ **4**	☐ **3**	☐ **2**	☐ **0**
Needs total physical support to eat.	Needs some physical help in order to eat.	Needs moderate support in the form of training in how to use utensils, how to eat at age level.	Needs help in the form of reminders with manners and appearance when eating.	Needs no support. At age level in eating.

___ 7. What support is needed for the person to prepare nutritional foods for self and others?

☐ 5	☐ 4	☐ 3	☐ 2	☐ 0
Total preparation of food by others.	With complete supervision and some physical assistance person may select and prepare some foods.	From available supplies prepares nutritious simple foods for breakfast and lunch which meet nutritional needs.	With supervision plans, buys and prepares more complex nutritious best-liked foods.	Needs no support. Plans, prepares nutritional diet (may have adapted environment.

___ 8. What support is needed for the person to do home-management tasks at age-level?

☐ 5	☐ 4	☐ 3	☐ 2	☐ 0
Needs physical support all household tasks done by others.	Needs physical assistance, supervision in performance of all household tasks.	Needs moderate support in the form of training in some home management tasks.	With monitoring, prompting completes all household tasks.	Needs no support in doing daily household tasks (may have adapted environmental/ physical supports).

___ 9. What support does the person need to manage own money with age-level skills?

☐ 5	☐ 4	☐ 3	☐ 2	☐ 0
Someone else must handle all of person's money.	Someone else must do all planning and closely supervise all money management.	With weekly supervision person plans and manages money.	Needs periodic monitoring in budgeting.	Needs no supports in managing money.

___ 10. What support is needed for the person to make age-level purchases?

☐ 5	☐ 4	☐ 3	☐ 2	☐ 0
Someone else must make all purchases.	Someone else must closely supervise all shopping.	With weekly supervision person shops for self.	Needs periodic monitoring in deciding where, when, how much to spend.	Needs no system supports in making purchases.

___ 11. What support does the person need to most effectively relate to fellow workers and/or students?

☐ 3	☐ 2	☐ 1	☐ 0	☐ 0
Needs physical support by others in the form of interpretation of self to others to interact with peers.	Needs physical intervention in the form of modeling to enable person to reach out to peers to give and take support.	Needs much encouragement, supervision and guidance in how to give and ask for support and interact with peers.	Needs minor support in the form of encouragement to initiate interaction with other workers/ students.	Without support, person relates to others as a valued member of Work/ Learning unit.

___ 12. What support does the person need to most effectively relate to his/her supervisor(s) and/or teacher(s)?

☐ 3	☐ 2	☐ 1	☐ 0	☐ 0
Supervisor must initiate all contact for work instruction, work accomplishment.	Needs major support in relating to supervisor. Recognizes authority but needs daily intervention in order to learn what a supervisor does and how to use that person.	Needs moderate support in relating to supervisor. Recognizes role of supervisor but needs significant instruction in how and when to use supervision appropriately.	Needs minor support in the form of monitoring to seek direction appropriately, follow through on work instruction and find ways to settle differences.	Needs no support. Relates effectively with supervisor/ teacher, i.e., seeks out supervisor appropriately; accepts supervision and direction; and follows through on work instruction.

___ 13. What support does the person need to take responsibility for getting to work and/or school on time?

☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Requires total physical support.	With major support from someone else in some but not all activities, person gets to work/school on time.	With moderate support in the form of some training and some physical supports person takes responsibility for self.	Needs some monitoring to ensure physical support is working or training remains effective.	Needs no support.

___ 14. What support is needed for person as an adult to earn at least minimum wage?

☐ **25**	☐ **16**	☐ **9**	☐ **4**	☐ **0**
Current system unable to overcome substantial health or physical disabilities of person to insure marketable work skills.	Major support required for person to maintain work career. One-to-one training on new tasks which are systematically broken down and done in sequential steps is needed for marketable skill.	Needs identification of own individual marketable interest and skill and specialized training. May also need environmental modification or specific adaptive device.	Has identified own marketable work skills/career option; needs special support in typical job market to identify and obtain specific job.	Has identified marketable work skills/career and is at age-level in finding a job.

___ 15. What support is needed for person to have age-level relationship with family members?

☐ **25**	☐ **16**	☐ **9**	☐ **4**	☐ **0**
Opportunities for contributing to family life totally dependent on others to maintain, interpret person's role in family.	Requires major support in the form of daily/weekly creation of opportunities to be seen as a contributing member of the family.	Requires moderate support in the form of adaptive device, training and reminders to be seen as a contributing member of the family.	Needs minor support in seeing self and being seen as a contributing member of the family.	Needs no support to form positive family relationship.

___ 16. What support is needed for person to make friendships with others including non-handicapped persons outside the family?

☐ **25**	☐ **16**	☐ **9**	☐ **4**	☐ **0**
Opportunities for establishing relationships are totally dependent on physical help from others to initiate and maintain, contact and interpret self to others.	Requires daily support to insure person is not seen by others and self as very different from others and/or as much younger and dependent.	Requires weekly encouragement to reach out to others to form relationships which are typical to person's age group.	Initiates, forms and participates in typical relationships in which person needs minor support in access to a variety of opportunities to see self or be seen as contributing member of relationships.	Needs no support. has a variety of opportunities to initiate, form and participate in relationships which are typical to other of the same age. (Person assumes typical roles which are valued by self and others.)

___ 17. What support is needed for the person to use typical community resources (including leisure time) at age level?

☐ **4**	☐ **3**	☐ **2**	☐ **1**	☐ **0**
Needs total physical support in selecting, planning and using typical resources.	Needs major support in the form of individualized instruction and ongoing supervision of participation.	Needs moderate support in the form of instruction and periodic monitoring.	Needs minor support in the form of information and encouragement to plan and use resources.	Needs no support. uses typical integrated community resources at age level.

___ 18. What support does the person need to use general community transportation system?

☐ **5**	☐ **4**	☐ **3**	☐ **1**	☐ **0**
Requires specialized transportation with major adaptation for all activities.	Needs specialized support for transportation to all activities (includes intensive one-on-one training or supervision).	Moderate support needed in use of typical transportation, i.e., support training supervision.	Needs minor support in using transportation for unfamiliar situations.	Needs no support. Uses transportation at age level.

ASSESSMENT - CURRENT SUPPORT NEEDS	NAME

SCORES	AGE-LEVEL RESIDENCE (OUTCOME)

___ 19. What support is needed for this person to have behaviors which promote being included?

☐ 25	☐ 16	☐ 9	☐ 4	☐ 0
Needs major tolerance and control. Could include being dangerous to self and/or others.	Needs major behavior modifications to be perceived as typical. Person's behaviors are extremely disagreeable to others.	Needs participation in typical settings with non-handicapped others to model desirable behaviors. Person's behaviors cause him/her to be easily recognized as different from others.	Needs interactions with non-handicapped people. Person's behaviors are different from others in minor ways and the person may not immediately be perceived as different.	Needs no support. Behaviors are similar to others in general community of same age and culture.

___ 20. What support does the person need to make those arrangements which meet own therapy and health needs?

☐ 25	☐ 16	☐ 9	☐ 2	☐ 0
Person needs medical health intervention by professionals at least daily.	Person needs frequent daily/weekly support and/or monitoring by trained others.	Needs consistent supervision of health and instruction in how to take care of own health needs. May need some physical support.	Needs occasional (monthly or less) monitoring of health needs, reminders.	Needs no support. Person takes care of own health needs.

Total of Items 1 - 20 above. (A minimum score of 40 is required for waiver.)

CASE/RESOURCE MANAGER'S SIGNATURE	DATE

ATTACHMENT D-3-a-4 – (click on Icon for CARE tool)

15_270.itp

If you cannot open the form, go to: http://www.dshs.wa.gov/dshsforms/forms/eforms.html and download the Shana Informed Filer available at that site.

Also, the pages are printed out in the hard copies of this waiver application.

ATTACHMENT D-3-b

WASHINGTON STATE DEPARTMENT OF PERSONNEL

Specification for Class of
DEVELOPMENTAL DISABILITIES CASE/RESOURCE MANAGER (35610)

Definition: Within the Division of Developmental Disabilities, provides advanced level of social services, specialized case and/or resource management for people who have developmental disabilities and their families.

Typical Work:
Independently manages a caseload of people who have developmental disabilities and provides specialized services to clients and their family by developing, implementing and monitoring Individual Service Plans; Interprets state and federal regulations to established boards, citizen groups, providers/vendors and others concerned and involved with services for people with developmental disabilities;
Coordinates resource programs with case management services, DSHS Offices, county coordinators, Adult Family Homes, county boards, and other vendors; Provides support services and oversight to Adult Family Home providers to enhance health, safety, and quality of life for DD residents; Recommends, monitors and manages specialized funding for medical expenses and social absences for group homes; screens billings for county services and group homes; Final decision authority on determinations of client eligibility, and provides intake services; evaluates individuals for admission to residential habilitation centers; assessment of client needs, including diagnoses and evaluation of individual clients who have behavioral, social and emotional problems; Arranges for special placement and other residential, vocational and recreational supports for children and/or adults; Assists and/or makes referral to the appropriate professional (i.e. Mental Health, Children's Protective Services, etc.) in reducing and/or preventing community and client problems; Assesses/evaluates facility situations, makes recommendation, and plans for family/community support service, including respite care, chore, day program for adults, early childhood development program, therapies and others; As a Qualified Mental Retardation Professional (QMRP), maintains compliance with Federal IMR and CAP regulations; Develops corrective action plans and reports in response to evaluations Quality Improvement AFH visits and other audits; assists contractor to comply with contract, and takes appropriate actions; Performs other work as required.

Minimum Qualifications:
A Bachelor's degree in social sciences, social services. human services, behavioral sciences or an allied field and two years of experience providing social services to people with developmental disabilities. Graduate training in social science, social services, human services, behavioral sciences or an allied field will substitute, year for year, for one year of the experience providing social services to people with developmental disabilities.

New class: Effective July 1, 1988 (approved June 9, 1988)
Revised definition and general revision: 6-11-99; effective 7-1-1999
Revised minimum qualifications, effective: 03-09-01
Revised definition: 5-30-02

ATTACHMENT D-3-c

WASHINGTON STATE DEPARTMENT OF PERSONNEL

Specification for Class of

SOCIAL WORKER 1

Definition: Within the Department of Social and Health Services, is the entry level trainee classification for the professional social services series in either Aging and Adult Services, Children and Family Services, or Economic and Medical Services. The clients served may be children or families in which risk of child abuse or neglect are minimal, or adults with disabilities resulting from varying degrees of incapacity, or vocational, social, cultural or health impairments that hinder economic or residential independence. All positions at this level receive close, detailed supervision.

Distinguishing Characteristics: Employees allocated to this classification receive extensive and advanced level on- and off-site structured training, both generic and division specific. In the first six months, cases are not assigned to this classification. When cases are assigned, they are pre-screened, closely supervised, and limited in number and complexity. As a component of their training program, incumbents shall assist professional level staff with cases that will enable them to experience a full range of division specific service functions. Employees remain in this classification for 18 months and then automatically promote to the Social Worker 2.

IN *AGING AND ADULT SERVICES:*

Receive training in:

- assessment
- licensing activities
- protective services
- community placement
- information and referral
- social support services
- case management

IN *CHILDREN AND FAMILY SERVICES:*

Receive training in:

- risk assessment
- licensing activities
- protective services
- information and referral
- case monitoring

IN *ECONOMIC AND MEDICAL SERVICES:*

Receive training in:

- assessment of employability
- information and referral
- medical treatment

Attachment D-3-c continued

- vocational training
- social support services

Typical Work

Under close supervision, experience/perform the full range of specific service functions, such as: interviewing children, parents, and others; case assessment, formulation and implementation of service plans; legal intervention;
Participates in staff conferences and required in-service training that is program area specific, department wide, or between agencies;
Participates in in-house case staffing;
Participates in multi-disciplinary team/multi-agency staffings;
Studies and applies principles and techniques of casework;
Interviews families/individuals for basic information relating to social history;
Identifies economic, social, cultural, physical, and environmental factors which support or limit family or individual functioning;
Implements and monitors appropriate service objectives or treatment plans;
Coordinates with appropriate intra- and inter-agency organizations to meet service goals or treatment plan objectives;
Identifies needs requiring services and enables clients to resolve needs through referral to appropriate resources;
Explains department policies and provisions of the law to families, individuals, and members of the community;
Develops and maintains case records relative to client needs, and steps taken to alleviate those needs utilizing prescribed agency forms and reports;
Performs other related work as required.

Knowledge and Abilities

Knowledge of: goals and objectives of services to adults and children; child welfare social services; laws, rules and regulations in the field of public welfare/child welfare; social casework principles and practices; social and economic conditions which affect the work of a public social service agency; interviewing techniques; social problems which call for the use of public and private community resources; principles of individual and social development, vocational counseling, and psychology; medical terminology and services; job training and educational resources; community resources.
Ability to: learn and act upon new information; work cooperatively with individuals and groups and be able to coordinate service plans with other social service agencies; exercise mature and sound judgment in problem solving and the decision making process; organize own work; present material effectively in written and oral form; properly and accurately document activities, paper flow; identify economic, social, cultural, physical and environmental factors which support or limit family or individual functioning; learn and apply principles of psycho-social casework.

Minimum Qualifications

A Master's degree in social services, human services, behavioral sciences, or an allied field.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field and one year of social service experience.

NOTE: Employees must successfully complete the formal training course sponsored by their division within eighteen months of their appointment.
New class: 8-1-88
Revised minimum qualifications: 1-12-90
Revised minimum qualifications: 6-15-90

APPENDIX D-4 freedom of choice and fair hearing

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

a. informed of any feasible alternatives under the waiver; and
b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:
For each waiver client, a copy is maintained by the case manager in the official client file housed in the local DDD office.

Attachment D-4-a

RCW 71A.10.050

Appeal of department actions -- Right to.

(1) An applicant or recipient or former recipient of a developmental disabilities service under this title from the department of social and health services has the right to appeal the following department actions:

(a) A denial of an application for eligibility under RCW 71A.16.040;

(b) An unreasonable delay in acting on an application for eligibility, for a service, or for an alternative service under RCW 71A.18.040;

(c) A denial, reduction, or termination of a service;

(d) A claim that the person owes a debt to the state for an overpayment;

(e) A disagreement with an action of the secretary under RCW 71A.10.060 or 71A.10.070;

(f) A decision to return a resident of an [a] habilitation center to the community; and

(g) A decision to change a person's placement from one category of residential services to a different category of residential services.

The adjudicative proceeding is governed by the Administrative Procedure Act, chapter 34.05 RCW.

(2) This subsection applies only to an adjudicative proceeding in which the department action appealed is a decision to return a resident of a habilitation center to the community. The resident or his or her representative may appeal on the basis of whether the specific placement decision is in the best interests of the resident. When the resident or his or her representative files an application for an adjudicative proceeding under this section the department has the burden of proving that the specific placement decision is in the best interests of the resident.

(3) When the department takes any action described in subsection (1) of this section it shall give notice as provided by RCW 71A.10.060. The notice must include a statement advising the recipient of the right to an adjudicative proceeding and the time limits for filing an application for an adjudicative proceeding. Notice of a decision to return a resident of a habilitation center to the community under RCW 71A.20.080 must also include a statement advising the recipient of the right to file a petition for judicial review of an adverse adjudicative order as provided in chapter 34.05 RCW.

[1989 c 175 § 138; 1988 c 176 § 105.]

NOTES:

Effective date -- 1989 c 175: See note following RCW 34.05.010.

Attachment D-4-b

WAC 388-825-100 Notification. (1) The department shall notify the client or applicant, the parent when the client or applicant is a minor, and the guardian when the client or applicant is an adult, of the following decisions:

(a) Denial or termination of eligibility set forth in WAC 388-825-100;

(b) Development or modification of the individual service plan set forth in WAC 388-825-050;

(c) Authorization, denial, reduction, or termination of services set forth in WAC 388-825-100; and

(d) Admission or readmission to, or discharge from, a residential habilitation center.

(2) The notice shall set forth appeal rights pursuant to WAC 388-825-120 and a statement that the client's case manager can be contacted for an explanation of the reasons for the action.

(3)(a) The department shall provide notice of a denial or partial authorization of a family support services request and a statement of reason for denial or partial authorization, or reduction to the person or persons described in subsection (1) of this section. The department shall send such notice no later than five working days before the end of the month previous to the month for which service was requested;

(b) The department shall make available an administrative review of a decision to deny or partially authorize services upon receipt of a written request by a person or persons described in subsection (1) of this section to the administrator of the region in which the client is living. The regional office must receive a request for administrative review by the last working day of the month;

(c) The client shall state in the written request why the client or client's family believes their service priority designation is not correct;

(d) Upon receipt of request for administrative review, the regional administrator or designee shall review the request and the client file; and

(e) The department shall send the results of the administrative review to the client and/or family within the first five working days of the service month for which the client is being denied or receiving a partial authorization for services.

(4) The department shall provide at least thirty days' advance notice of action to terminate a client's eligibility, terminate or reduce a client's service, or discharge a client from a residential habilitation center to the community. Transfer or removal of a client from a service set forth in WAC 388-825-120 (5)(f) is governed by that section, and reduction of family support funding during the service authorization period is covered by subsection (3)(a) of this section.

(5) All parties affected by such department decision shall be consulted, whenever possible, during the decision process by the responsible field services regional office in person and/or by telephone.

(6) The division shall ensure notification to the school district in which a school-aged child is to be placed when a placement decision is reached.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-100, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-400, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-400, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-400, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-400, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-400, filed 3/16/78; Order 1143, § 275-27-400, filed 8/11/76.]

Attachment D-4-c

WAC 388-825-120 Adjudicative proceeding. (1) A client, former client, or applicant acting on the applicant's own behalf or through an authorized representative has the right to an adjudicative proceeding to contest the following department actions:

(a) Denial or termination of eligibility set forth in WAC 388-825-100;

(b) Development or modification of the individual service plan set forth in WAC 388-825-050;

(c) Authorization, denial, reduction, or termination of services set forth in WAC 388-825-100;

(d) Admission or readmission to, or discharge from, a residential habilitation center;

(e) A claim the client, former client, or applicant owes an overpayment debt;

(f) A decision of the secretary under RCW 71A.10.060 or 71A.10.070;

(g) A decision to change a client's placement from one category of residential services to a different category of residential services.

(2) Adjudicative proceedings are governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 71A.10.050, the rules in this chapter, and by chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC, the provision in this chapter shall govern.

(3) The applicant's application for an adjudicative proceeding shall be in writing and filed with the DSHS office of appeals within twenty-eight days of receipt of the decision the appellant wishes to contest.

(4) The department shall not implement the following actions while an adjudicative proceeding is pending:

(a) Termination of eligibility;

(b) Reduction or termination of service, except when the action to reduce or terminate the service is based on the availability of funding and/or service; or

(c) Removal or transfer of a client from a service, except when a condition in subsection (5)(f) of this section is present.

(5) The department shall implement the following actions while an adjudicative proceeding is pending:

(a) Denial of eligibility;

(b) Development or modification of an individual service plan;

(c) Denial of service;

(d) Reduction or termination of service when the action to reduce or terminate the service is based on the availability of funding or service;

(e) After notification of an administrative law judge's (or review judge) ruling that the appellant has caused an unreasonable delay in the proceedings; or

(f) Removal or transfer of a client from a service when:

(i) An immediate threat to the client's life or health is present;

(ii) The client's service provider is no longer able to provide services due to:

(A) Termination of the provider's contract;

(B) Decertification of the provider;

(C) Nonrenewal of provider's contract;

(D) Revocation of provider's license; or

(E) Emergency license suspension.

(iii) The client, the parent when the client is a minor, or the guardian when the client is an adult, approves the decision.

(6) When the appellant files an application to contest a decision to return a resident of a state residential school to the community, the procedures specified in RCW 71A.10.050(2) shall govern the proceeding. These procedures include:

(a) A placement decision shall not be implemented during any period during which an appeal can be taken or while an appeal is pending and undecided unless the:

(i) Client's or the client's representative gives written consent; or

(ii) Administrative law judge (or review judge) after notice to the parties rules the appellant has caused an unreasonable delay in the proceedings.

(b) The burden of proof is on the department; and

(c) The burden of proof is whether the specific placement proposed by the department is in the best interests of the resident.

(7) The initial order shall be made within sixty days of the department's receipt of the application for an

Attachment D-4-c continued

adjudicative proceeding. When a party files a petition for administrative review, the review order shall be made within sixty days of the department's receipt of the petition. The decision-rendering time is extended by as many days as the proceeding is continued on motion by, or with the assent of, the appellant.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-120, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-500, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-27-500, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-500, filed 8/29/86. Statutory Authority: RCW 72.33.161. 84-15-038 (Order 2122), § 275-27-500, filed 7/13/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-500, filed 3/16/78; Order 1143, § 275-27-500, filed 8/11/76.]

Attachment D-4-d

VOLUNTARY PARTICIPATION FORM
FOR THE
HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER

Client Name (print)_____ DDD # _____

You are being considered for service under the HCBS Waiver. The HCBS Waiver is authorized under Title XIX of the Social Security Act to provide home and community-based care for eligible individuals.

I have been informed of my alternatives and choose to receive service under the Waiver.

Client Signature _____ Date_____

Legal Representative Signature _____ Date _____

I have been informed of my alternatives and choose to receive institutional services.

Client Signature _____ Date_____

Legal Representative Signature _____ Date _____

_____ _____

Case/Resource Manager **Date**

CC: Client or legal representative
Client File

Attachment D-4-e

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
NOTIFICATION OF TERMINATION OF WAIVER SERVICES
DUE TO INELIGIBILITY FOR MEDICAID

DATE:

TO: (ADDRESS LABEL)

RE:

FROM: **TELEPHONE:**

Why am I getting this letter?
DDD has learned that you **no longer qualify for Medicaid** under the categorically needy (CN) program. While DDD does not make Medicaid eligibility decisions, we must terminate your eligibility for the Waiver program and Waiver services if you are not Medicaid eligible.

What law or rule is this decision based on?
This requirement is in Appendix C of the Waiver and the rules are in WAC 388-513-1315.

What affect does termination from the Waiver have on my current DDD paid services?
If you are not on the Waiver, your DDD services are not guaranteed and are limited by the availability of funding.

☐ **The following services will be terminated as of _____**

- ☐ Respite Care
- ☐ Attendant Care
- ☐ Residential services
- ☐ Child Foster Care
- ☐ Other: _____
- ☐ Employment/Day Program
- ☐ Professional Services
- ☐ Medically Related Services
- ☐ Medicaid Personal Care

☐ **The following funded services will be continued:**

- ☐ Respite care
- ☐ Attendant Care
- ☐ Residential services
- ☐ Child Foster Care
- ☐ Employment/Day Program
- ☐ Professional Services
- ☐ Medically Related Services
- ☐ Other: _____

Do I have appeal rights to my Waiver termination?
Appeal of termination of services: You have a right to appeal any termination or

reduction of services. A Request for Appeal form is enclosed if any services are being terminated.

- You have 28-days from receipt of this notice to request an appeal.
- Your services will not continue during appeal.

If you need help to do this, call DDD at the number provided at the top of this notice and request assistance to file an appeal.

Appeal of Medicaid eligibility decision: Your Waiver termination is due to termination of Medicaid eligibility made by another part of DSHS. You were sent appeal rights with the written notification of your Medicaid termination.

Is there anything I can do to keep my eligibility and services?
You cannot keep your waiver eligibility or services unless your Medicaid eligibility is reinstated.

Can I get back onto the Waiver in the future?
You can reapply for Waiver services if you are eligible for Medicaid. [WAC 388-513-1315]. The number of people who can be on the Waiver at any point in time may also limit future access to the Waiver.

Who should I call if I still have questions?
Please call your case/resource manager whose name and phone is at the top of this notice.

Enclosures:

CC: Other person as required for notification
Client File

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
PO BOX 45310 OLYMPIA WA 98504-5310

DATE: _____

TO:

NOTIFICATION OF INELIGIBILITY FOR ICF/MR SERVICES AND THE CAP WAIVER

RE: _____,

FROM: _____ TELEPHONE: _____

Why am I getting this notice?

On _____ DDD completed your annual eligibility reassessment for the Community Alternative Program (CAP) Waiver and has determined that you are no longer eligible for the CAP Waiver. You have a right to understand and to appeal this decision.

Why am I no longer eligible for the CAP Waiver?

The DDD Nursing Care Consultant (NCC) has determined that you do not meet eligibility for ICF/MR services. The NCC's decision is based on a review of your Current Support Needs assessment and other available information regarding your habilitation needs.

What law or rule is this decision based on?

This decision is based on Washington Administrative Code (WAC) sections 388-825-180(1)(d).

WAC 388-825-180 Eligible persons.

(1) To be eligible to apply for Community Alternatives Program (CAP) services, the individual must:
- (a) Meet the criteria for the Division of Developmental Disabilities (DDD) eligibility.
- (b) Meet the criteria for disability as established in the Social Security Act.
- (c) Have an income of less than 300% of the federal Supplemental Security Income (SSI) benefit amount.
- **(d) Need an IMR level of care as determined by a DDD Nursing Care Consultant.**
  - (i) Require 24 hour care and require services that cannot be provided by a family member; and
  - (ii) Have a documented need for habilitation services and training.
  - (iii) Participation in CAP is by choice of the otherwise IMR-eligible person.

What affect does my termination from the CAP Waiver have on my current DDD services and Medicaid benefits?

_____

_____

_____

_____

Can I appeal this decision?

IF YOU DISAGREE WITH THIS DECISION, you have 28 days from receipt of this letter to request a fair hearing. The above decision will take effect on _____ unless a fair hearing is requested. If a fair hearing is requested, services will continue until a decision is issued on your fair hearing.

To request a fair hearing, you can call your case/resource manager or complete and mail the enclosed "Request for Hearing" form to the OFFICE OF ADMINISTRATIVE HEARINGS, PO BOX 42489, OLYMPIA WA 98504-2489. For additional online information about the Fair Hearings process, access http://oah.wa.gov.

Date mailed: _____
Date personally delivered to client: _____

Enclosures: CAP Assessment form with score
ICF/MR determination form from NCC
Request for Hearing form

DSHS 10-298 (12/2002) TRANSLATED

Attachment D-4-g
(signature page from plan of care)

I have participated in the development of and/or reviewed this Individual Plan of Care and agree to the outcomes and services and supports described. I understand that I have the right to withdraw or not consent to the services outlined in the plan. My rights to appeal the decisions made by the Division of Developmental Disabilities have been explained to me. The procedures for making an appeal have been explained to me.

Without signatures & dates the plan will **not** be valid.

CRM must be the last one to sign.
Do **not** backdate!!!

SIGNATURES

Waiver Participant: _____Date:

Parent/Guardian: _____Date:

Case/Resource Manager: _____Date:

Request for Administrative Hearing/Appeal

I,_____, (check one box)

- ❑ The person for whom services are requested
- ❑ Parent/guardian for _____ who is under the age of 18
- ❑ Guardian

Request an administrative hearing to review the decision of the Division of Developmental Disabilities – Field Services as set forth in this Plan of Care.

I, (check one box)

- ❑ Will NOT be represented by an attorney.
- ❑ Will be represented by an attorney.

Name of attorney _____

Client's Signature Parent/Guardian's Signature

Street Address City Zip

Telephone number

This form must be completed and returned within 30 days to appeal this decision
To request a hearing, complete the above form and mail to the OFFICE OF ADMINISTRATIVE HEARINGS, PO BOX 42289, OLYMPIA WA 9507-2489 OR deliver to a Regional Office of the Division of Developmental Disabilities within 30 days.

Attachment D-4-h

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

REQUEST FOR HEARING

per Chapter 388-02 for DSHS fair hearing rules.

FOR AGENCY USE ONLY

☐ **Oral request taken by:**

NAME | TELEPHONE NUMBER

INVOLVED DIVISION/ORGANIZATION

MAIL TO: OFFICE OF ADMINISTRATIVE HEARINGS (OAH), MAIL STOP: 42489
PO BOX 42489
OLYMPIA WA 98504-2489

FAX: 360-586-6563

I request a hearing because I disagree with the following decision by the Department of Social and Health Services (DSHS):

- Explain briefly what DSHS did or did not do (add pages if you need more room); and
- Attach a copy of the notice you are appealing, if possible.

YOUR NAME (PLEASE PRINT) | DATE OF BIRTH | SOCIAL SECURITY NUMBER

ADDRESS OF PERSON REQUESTING HEARING | CLIENT ID NUMBER

CITY | STATE | ZIP CODE | TELEPHONE NUMBER (INCLUDE AREA CODE) ( ) ☐ MESSAGE PHONE

I was notified of the decision on: _____ (DATE) by: _____ (DSHS OFFICE NAME AND LOCATION)

I want continued assistance, if I am eligible: ☐ Yes ☐ No Program: _____

I am represented by (if you are going to represent yourself, do not fill in the next two lines):

YOUR REPRESENTATIVE'S NAME | ORGANIZATION | TELEPHONE NUMBER

ADDRESS STREET | CITY | STATE | ZIP CODE

☐ **I authorize release of information about my hearing to my representative.**

YOUR SIGNATURE | DATE

Do you need an interpreter or other assistance or accommodation for the hearing? ☐ Yes ☐ No

If yes, what language or what assistance? _____

Administrative Law Judges (ALJ's) may hold some hearings by telephone. If you want to change to an in-person hearing, follow the instructions in the Notice of Hearing that will be mailed to you by OAH.

DSHS 05-013 CA (REV. 08/2000)

APPENDIX E PLAN OF CARE

APPENDIX E-1 plan of care development

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:
___ Registered nurse, licensed to practice in the State
___ Licensed practical or vocational nurse, acting within the scope of practice under State law
___ Physician (M.D. or D.O.) licensed to practice in the State
___ Social Worker (qualifications attached to this Appendix)
_X_ Case Manager
___ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.
___ At the Medicaid agency central office
___ At the Medicaid agency county/regional offices
_X_ By case managers
_X_ By the agency specified in Appendix A
___ By consumers
___ Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:
___ Every 3 months
___ Every 6 months
_X_ Every 12 months
___ Other (specify):

APPENDIX E-2 agency approval, requirements and copy

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:
The Department of Social and Health Services (DSHS) is the single state Medicaid agency for the State of Washington. Case managers, who arrange a meeting with the client, guardian (if applicable), family members, advocates and other interested parties to develop plans of care, are state employees of DSHS and must approve and sign every plan of care. Their supervisors periodically review and approve service plans to ensure the needs of the client are being identified and met.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

INDIVIDUAL PLAN OF CARE

Waiver Participant? **Y N** Initial Plan ☐ Annual Plan ☐ Change of Status ☐
Basic ☐ Basic Plus ☐ Core ☐ Public Safety ☐

It is very important to verify that all information in this section is current and correct.

Ti If any of the information has changed be sure to enter the correct information into the CCDB immediately!

Please make sure to identify a contact in case of emergency, natural disaster or service-related.

SECTION ONE – PERSONAL DATA

Name_____ Date of Birth_____

Address_____ Telephone # _____

Social Security # _____ CSO # _____ DDD # _____

Significant Other _____ ☐ Parent/Family Member ☐ Guardian ☐ Advocate ☐ Other (describe)

Emergency Contact Name/Number _____
Case Manager _____ Phone # _____
Date of Planning Meeting _____
Attended Meeting:

Every effort must be made to include the people in the plan development process that the waiver participant would like.

Name	Relationship to Waiver Participant	**Name**	Relationship to Waiver Participant

Please note who attended the meeting and/or contributed to the plan. The participant **MUST** attend the meeting.

Contributed to plan but did not attend meeting:

Name	Relationship to Waiver Participant	**Name**	Relationship to Waiver Participant

The next step is to complete the Support Needs Assessment designed to assist in determining ICF/MR level of care. If the person does not score 40 points review all other available information to make an accurate level of care determination before proceeding with the planning process.

Please provide a brief description of the waiver participant and their situation as of this plan, i.e. who they are: male, female, age, etc. and where they live, major issues in their life.

Personal "Snapshot"

SECTION TWO – HEALTH INFORMATION

Remember! Get the dates.

Because dental and medical visits are so important to staying in the best of health, be sure there is a discussion explaining the reasons/benefits and offer assistance to connect with a doctor or dentist if needed.

If a refusal to see a doctor or dentist will jeopardize the person's health & welfare, a discussion will need to occur regarding their ability to receive waiver services.

Medical	**Dental**	**Other Health Services (Behavior Mgmt., OT, PT, etc.)**
Physician Name & Number: _____ _____ Status of ongoing health issues:	Dentist Name & Number: _____ _____ Status of ongoing issues:	Provider Name, Type & #: _____ _____ Status of Ongoing Issues:
New Concerns?		Provider Name, Type & #: _____ _____ Status of Ongoing Issues
If, after a discussion of the importance of yearly physicals the person/family/guardian refuses a physical, have them initial here: _____	If, after a discussion, the person/family/guardian chooses to see a dentist only one time yearly have them initial here: _____ If, after a discussion of dental visits, the person/family/guardian refuses to see a dentist have them initial here: _____	

Name:_____

This is very important information and an opportunity to make sure that proper medication management is happening for this person.

Medication Management:

Please list the medications you currently take and what they're for:

Who prescribes them & how often are they reviewed?

Do you need any help taking your medications? Please describe:

Do you have any concerns about your medication?

SECTION THREE – Current Supports & Resources

This information is important to have as a plan is developed for this person, so that all supports and resources may be considered in meeting health and welfare needs.

❑ Current Living Situation

_____

❑ Other service systems

_____

(DVR, MH, Substance Abuse, School services, etc.)

❑ Medicaid Personal Care (MPC)-# hours or "level of care" _____
❑ Medicare
❑ Other Medical insurance (Specify)

_____

❑ Basic Food – Monthly amount $_____
❑ Section 8 rental assistance $ _____
❑ SSI – Monthly amount $_____
❑ SSA/SSDI – Month amount $ _____

☐ SSP – Monthly amount $_____
☐ Wages - Monthly amount $ _____
☐ Other sources of income $ _____

❑ Total available monthly benefits $ _____

Name: _____

SECTION FOUR – Determining Health & Welfare Needs

If this is an initial plan this section does not have to be completed.

If this is an annual review, facilitate a discussion looking at how the current plan is working, what is working well and should continue, changes that need to be made and any new issues to be addressed.

These questions must be addressed to the waiver participant, their family/legal representative and any current providers.

Review of Current Plan

How are things going?

Which services and supports are meeting the individual's needs and should be continued as is?

Which services and supports are not adequately meeting the individual's needs, requiring some change?

Are there new needs to be addressed?

If the individual has a Comprehensive Assessment (CA), school plan, (IEP, 504 Plan), etc. review and include any needs information here.

Name:_____

It is vital to find out what the person and/or their family/guardian, feel is needed to meet the waiver participant's health and welfare needs.

This box should contain **only** items in addition to those already identified above.

Any Other Needs identified by the person/family/guardian

STOP

The team must discuss all the needs identified and agree which are necessary to ensure the waiver participant's health & welfare. Those must be addressed by this plan. If there are unmet health & welfare needs that will not be addressed by this plan document the reason why below.

Next discuss services and supports that might meet the agreed upon needs. This discussion must include ideas about unpaid as well as paid supports; state plan services as well as waiver services. Every waiver participant MUST be offered choice of qualified waiver providers. If a person has a current provider they are not happy with, the issue must be addressed and a plan of action arrived at that all are comfortable with.

Once the team feels they have a good idea of how to best meet the agreed upon needs go onto outline all the steps necessary to put the plan in place.

Explanation of any health & welfare needs that will not be addressed in this plan:

STATE:_____
DATE:_____

Name:_____

SECTION FIVE
A PLAN FOR MEETING AGREED UPON HEALTH AND WELFARE NEEDS

Need # _____:

What steps must be taken and/or what services/supports need to be in place to meet this need?	**Provider/ Responsible person?**	**Waiver Funded Service?**	**Frequency?** Daily/weekly/mthly **Duration?** 1 –12 months	**If new, what is the start date?**

Need #_____:

What steps must be taken and/or what services/supports need to be in place to meet this need?	**Provider/ Responsible person?**	**Waiver Funded Service?**	**Frequency?** Daily/weekly/mthly **Duration?** 1 –12 months	**If new, what is the start date?**

Name:_____

A PLAN FOR MEETING AGREED UPON HEALTH AND WELFARE NEEDS

Need #_____:

What steps must be taken and/or what services/supports need to be in place to meet this need?	**Provider/ Responsible person?**	**Waiver Funded Service?**	**Frequency?** Daily/weekly/mthly **Duration?** 1 –12 months	**If new, what is the start date?**

Need #_____:

What steps must be taken and/or what services/supports need to be in place to meet this need?	**Provider/ Responsible person?**	**Waiver Funded Service?**	**Frequency?** Daily/weekly/mthly **Duration?** 1 –12 months	**If new, what is the start date?**

Name:_____

SECTION SIX
WRAP-UP AND SIGNATURES

Plan Review

Once the plan for meeting health & welfare needs is completed a decision must be made as to the required frequency for monitoring of the plan. This decision is to be made based on the complexity of the plan and the fragility of the person and/or their supports. Check the appropriate box below. **This plan will be reviewed**

Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐

It is very important to have a discussion about the items, before asking for the person to initial them.

NOTE: Individuals must be given their appeal rights in writing every time there is a change in their plan.

ALL of the items below must be reviewed and checked for the plan to be finalized

- ❑ I received information regarding waiver services and providers I needed to complete the plan.
- ❑ I had a choice of providers for the supports I need.
- ❑ If any current provider is not to my satisfaction, I was able to plan to meet my needs in other ways.
- ❑ All of my health and safety needs are either currently being met or an adequate plan is in place to meet them in a timely manner.
- ❑ Any issues or concerns I brought up related to this plan of care have been addressed.
- ❑ I was treated respectfully
- ❑ I was given my rights of appeal, before signing the plan.
- ❑ I know I can request a review of this plan at any time.
- ❑ My rights to appeal the decisions made by the Division of Developmental Disabilities have been explained to me. The procedures for making an appeal have been explained to me.

This **must** be initialed! The person must be given information with which to make their choice.

I have been informed of and understand my choice of waiver services. I choose to receive waiver services rather than accept placement in an ICF/MR. _____
(waiver participant/legal representative initials)

Without signatures & dates the plan will **not** valid. Make sure the correct choice is circled

CRM must be the last one to sign.
Do **not** backdate!!!

I have participated in the development of and/or reviewed this Individual Plan of Care and **agree OR do not agree (circle one)** to the services and supports described. I understand that I have the right to withdraw or not consent to the services outlined in the plan. I understand that if I do not agree, the plan and the services described cannot be authorized and implemented without my signature.
SIGNATURES

Waiver Participant: _____Date: _____

Legal Representative: _____ Date: _____

Case/Resource Manager: _____Date: _____

REQUEST FOR ADMINISTRATIVE HEARING/APPEAL

I, _____, (check one box)

- ❑ The person for whom services are requested
- ❑ Parent/guardian for _____ who is under the age of 18
- ❑ Guardian

Request an administrative hearing to appeal the following decision of the Division of Developmental Disabilities – Field Services as set forth in this Plan of Care:

_____

I, (check one box)

- ❑ Will NOT be represented by an attorney.
- ❑ Will be represented by an attorney. Name of attorney _____

Client's Signature Parent/Guardian's Signature

Street Address City Zip

Telephone number

This form must be completed and returned within 28 days to appeal this decision

To request a hearing, complete the above form and mail to the OFFICE OF ADMINISTRATIVE HEARINGS, PO BOX 42489, OLYMPIA WA 98504-2489 OR deliver to a Regional Office of the Division of Developmental Disabilities within 28 days.

Name:_____

Plan Effective Date:_____

Waiver Cost Projections

Please identify each need with its number. List each waiver service on th plan and it's projected costs. You only need to project cost for waiver funded services. See the box below listing waiver service options. You will need to refer to the SSPS manual and the costing resource sheets available in your region to correctly identify the costs associated with each service. Please note the service level limits on individual services and combinations of services. If the Total Projected Annual Cost or any individual service level limit has been exceeded, check the box and obtain a prior authorization signature.

Waiver Services

BASIC WAIVER
Behavior Management and Consultation
Community Guide
Environmental Adaptations
Medical Equipment/Supplies
Occupational Therapy
Specialized Psychiatric Services
Physical Therapy
Respite Care
Speech, Hearing, Language
Staff/Family consultation and Training
Transportation
Personal care
Supported Employment
Community Access
Pre-vocational Services
Person to Person
Emergency Assistance
BASIC PLUS
Skilled Nursing and
all of the Basic Services
CORE
Residential habilitation and
all of the Basic Plus services except emergency assistance
PUBLIC SAFETY
All Core services except personal care, Respite, Community Guide and Community Access
(Some definitions differ in this waiver)

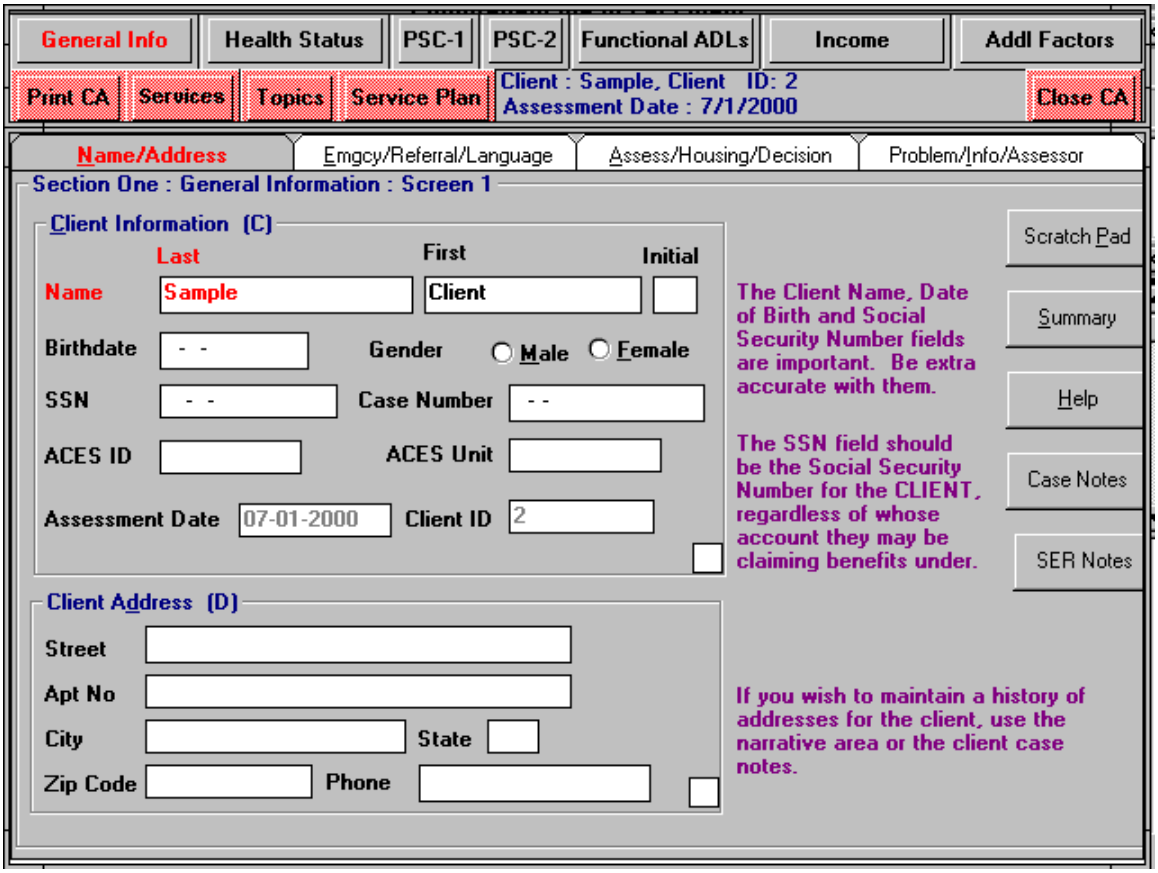
Need #	Unit (day/month/annual)	Unit cost	Projected Annual Cost	✓ if over limit
			Total Projected Annual Cost:	

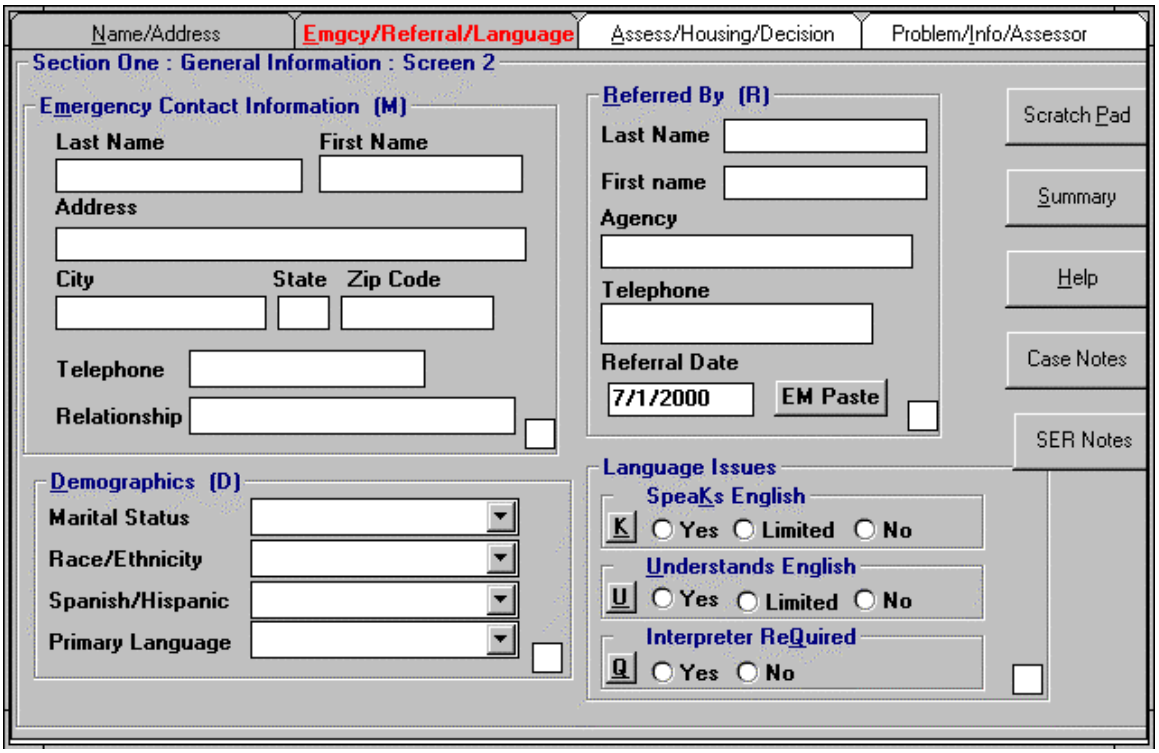
Prior Authorization Signature & Title:

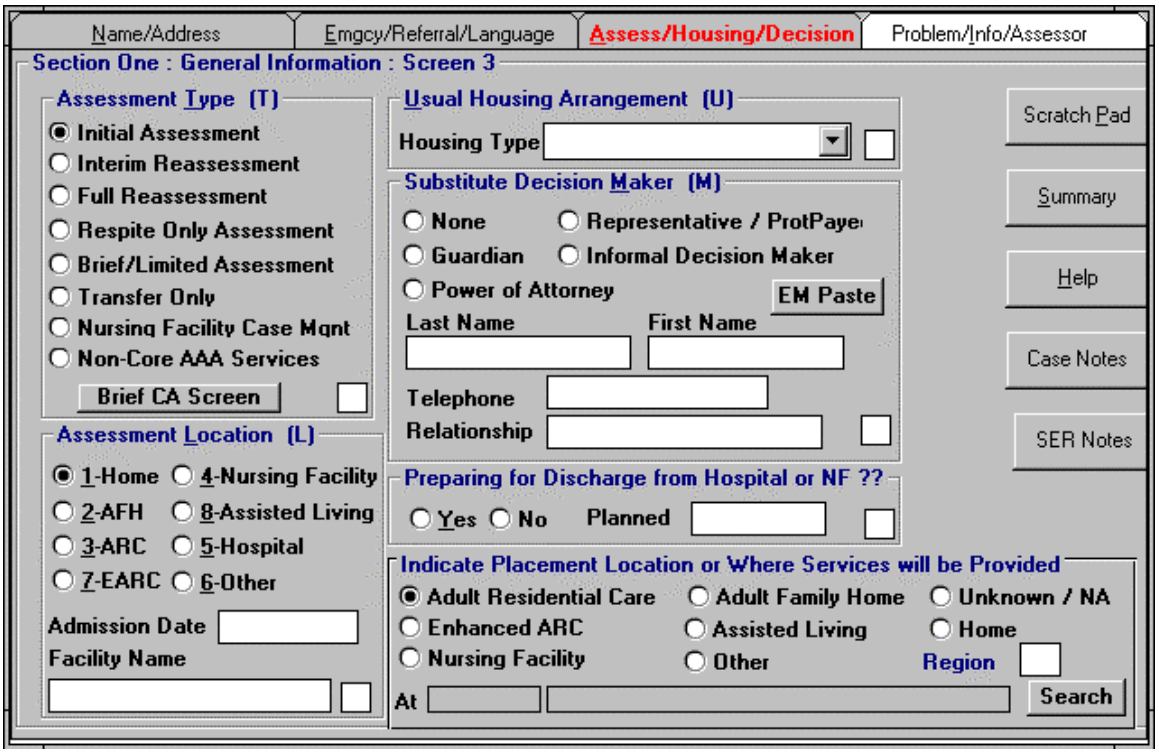
PLAN OF CARE CONTINUED – THE COMPREHENSIVE ASSESSMENT
This assessment and planning document will be used to evaluate personal care needs. It is the same as the evaluation and planning tool used for state plan personal care services.

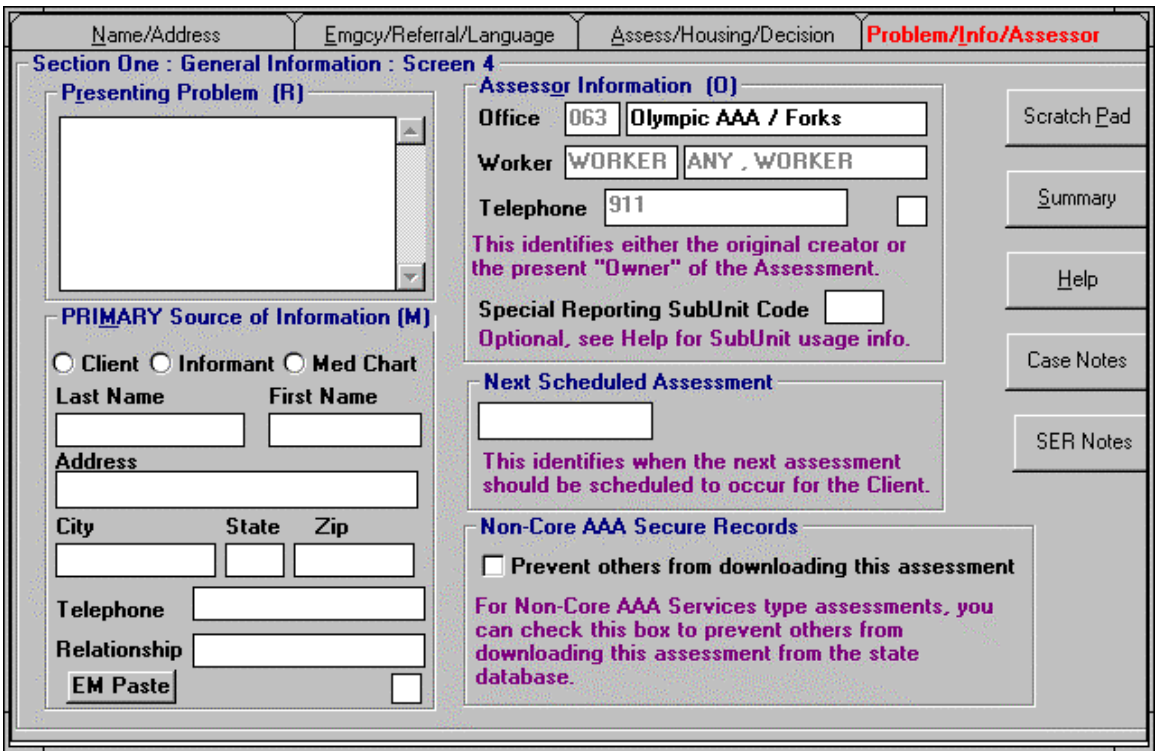
Comprehensive Assessment
Version 3.80 (Four Level Payment Structure)

Section I. General Information

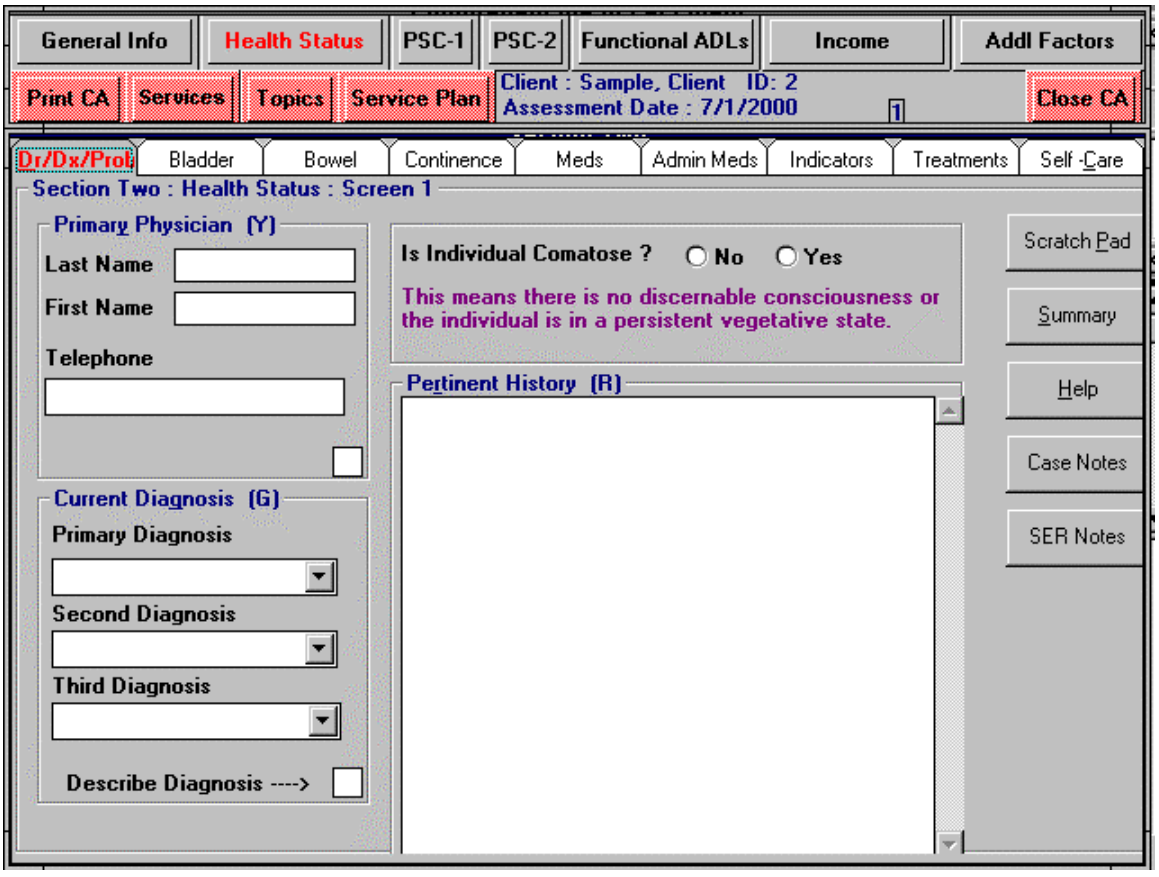


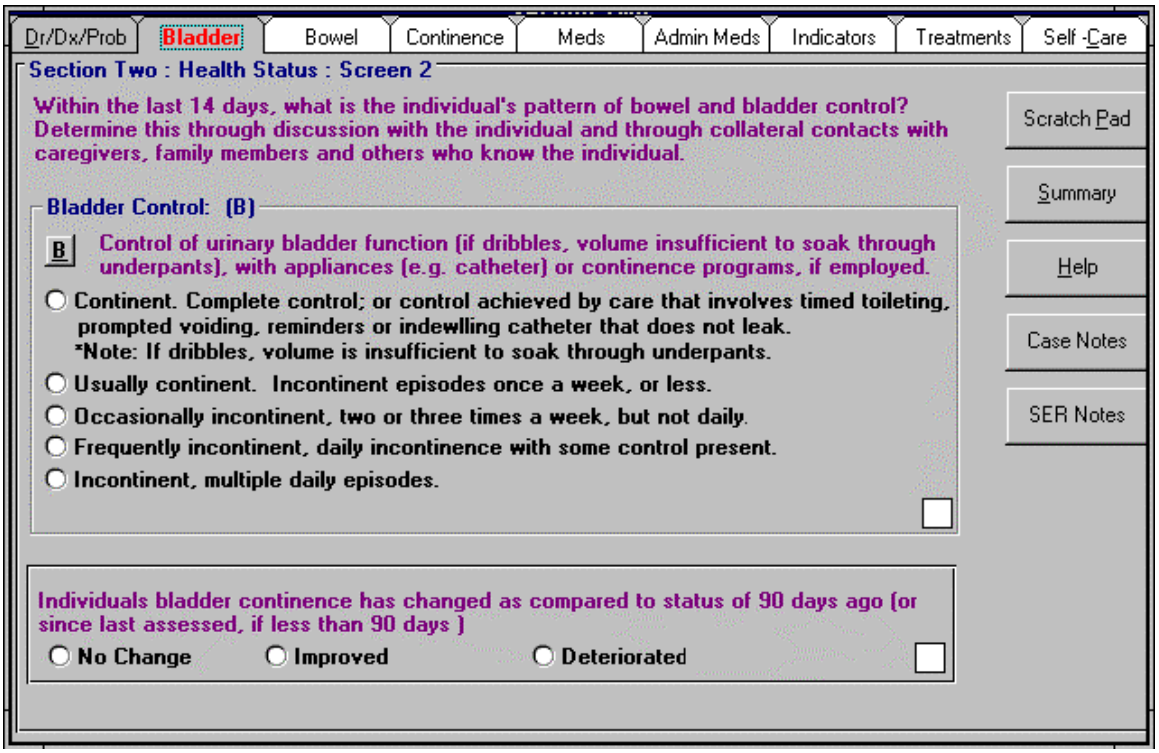

Name/Address
Emgcy/Referral/Language
Assess/Housing/Decision
Problem/Info/Assessor
Section One : General Information : Screen 2
Emergency Contact Information (M)
Last Name
First Name
Address
City
State
Zip Code
Telephone
Relationship
Referred By (R)
Last Name
First name
Agency
Telephone
Referral Date
7/1/2000
EM Paste
Demographics (D)
Marital Status
Race/Ethnicity
Spanish/Hispanic
Primary Language
Language Issues
SpeaKs English
K
Yes
Limited
No
Understands English
U
Yes
Limited
No
Interpreter ReQuired
Q
Yes
No
Scratch Pad
Summary
Help
Case Notes
SER Notes

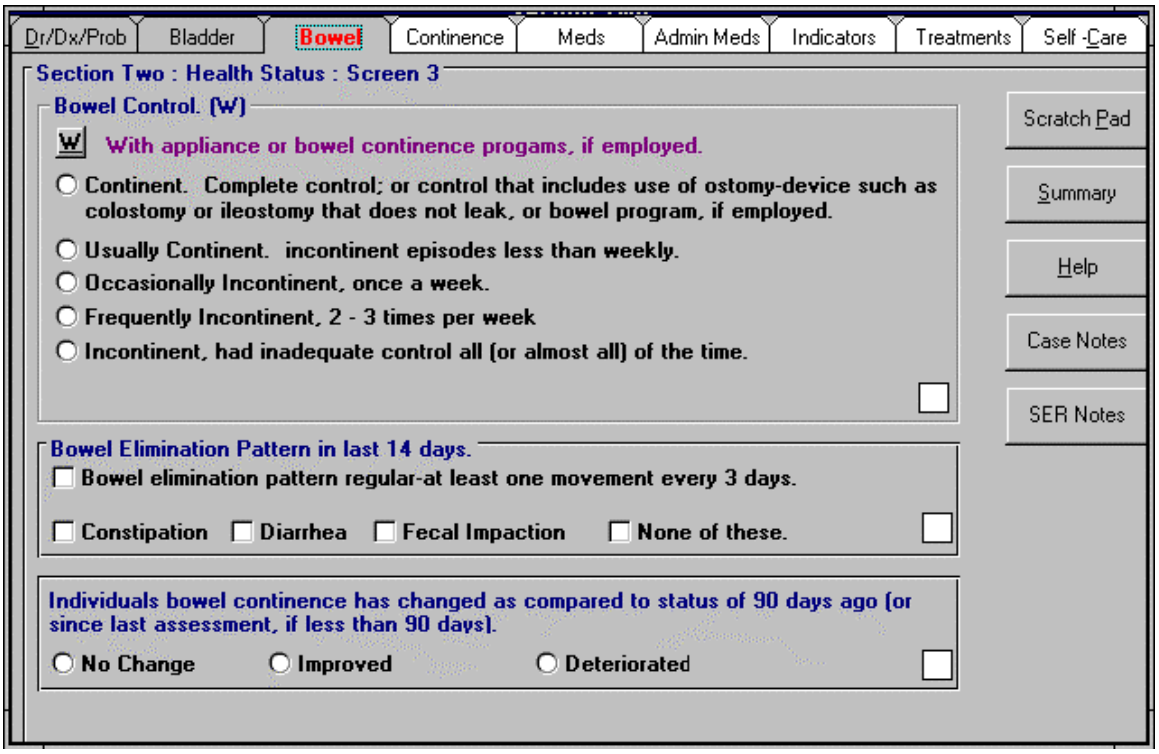

Name/Address
Emgcy/Referral/Language
Assess/Housing/Decision
Problem/Info/Assessor
Section One : General Information : Screen 3
Assessment Type (T)
Initial Assessment
Interim Reassessment
Full Reassessment
Respite Only Assessment
Brief/Limited Assessment
Transfer Only
Nursing Facility Case Mgnt
Non-Core AAA Services
Brief CA Screen
Assessment Location (L)
1-Home
4-Nursing Facility
2-AFH
8-Assisted Living
3-ARC
5-Hospital
7-EARC
6-Other
Admission Date
Facility Name
Usual Housing Arrangement (U)
Housing Type
Substitute Decision Maker (M)
None
Representative / ProtPaye
Guardian
Informal Decision Maker
Power of Attorney
EM Paste
Last Name
First Name
Telephone
Relationship
Preparing for Discharge from Hospital or NF ??
Yes
No
Planned
Indicate Placement Location or Where Services will be Provided
Adult Residential Care
Adult Family Home
Unknown / NA
Enhanced ARC
Assisted Living
Home
Nursing Facility
Other
Region
At
Search
Scratch Pad
Summary
Help
Case Notes
SER Notes

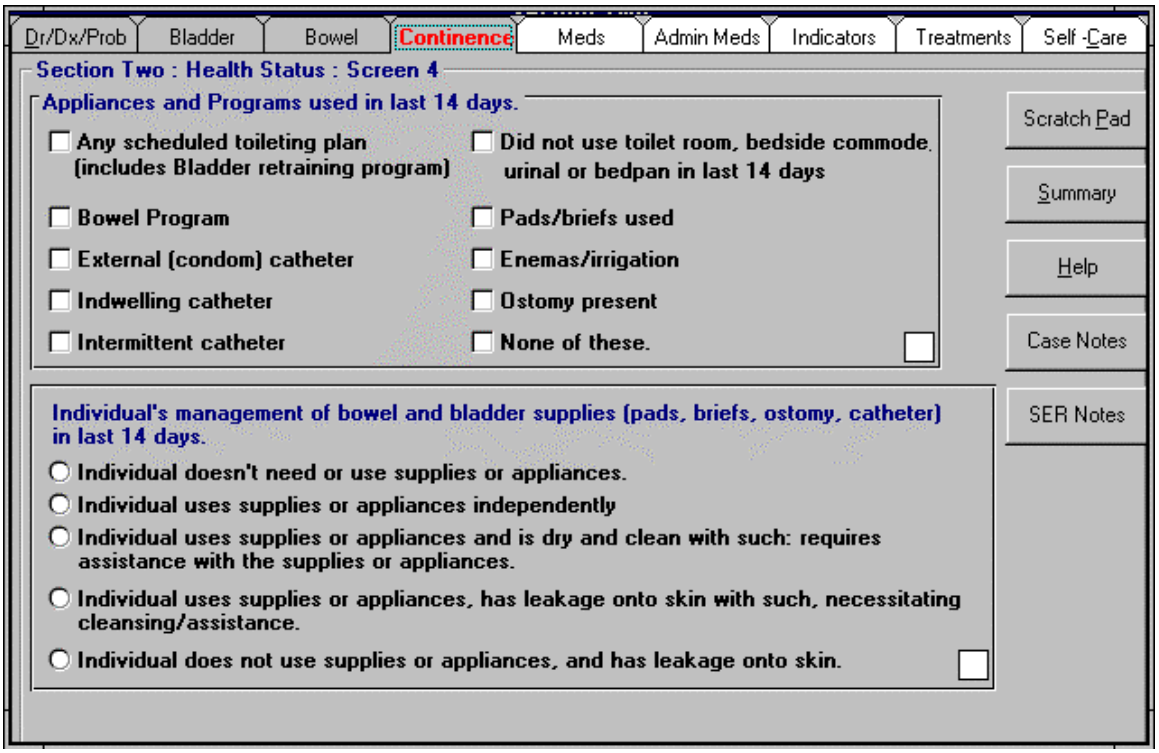


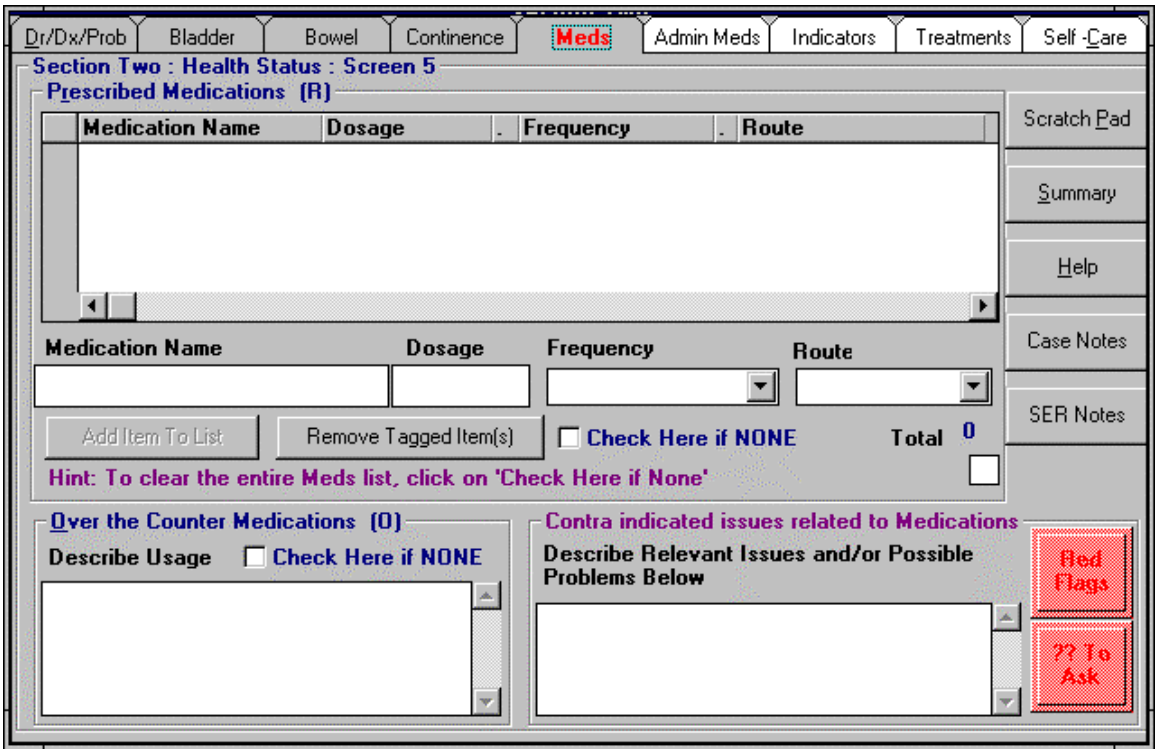
Section II. Health Status

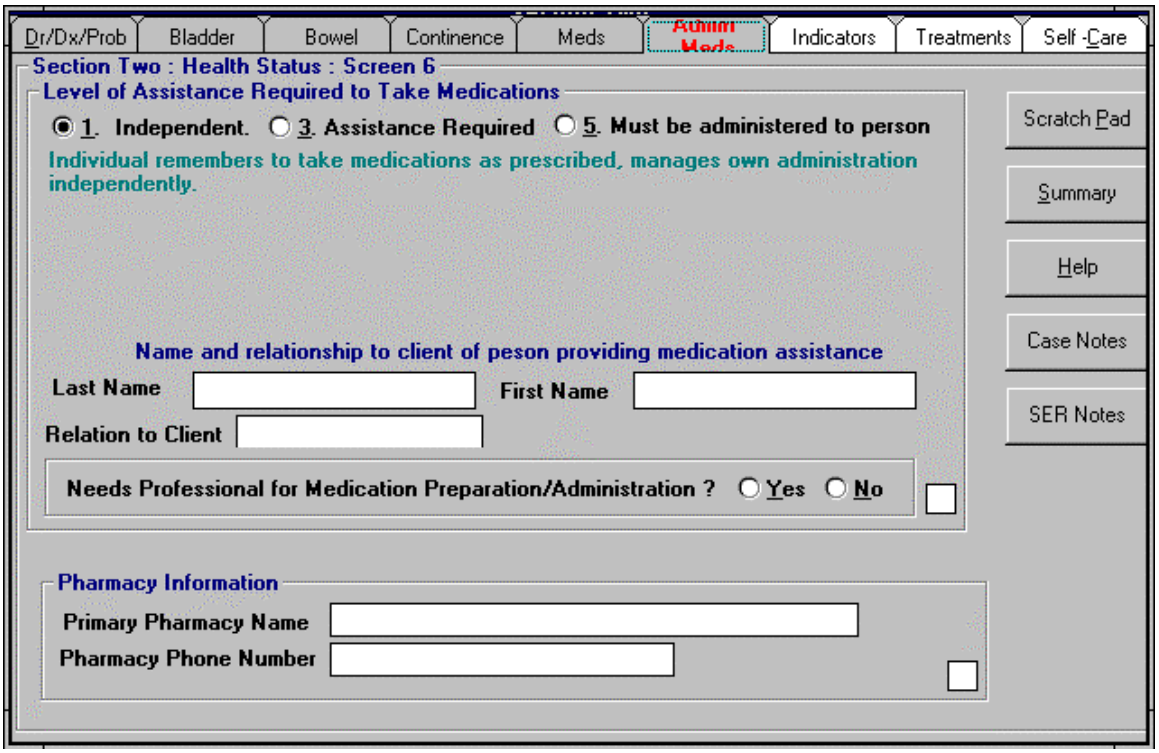


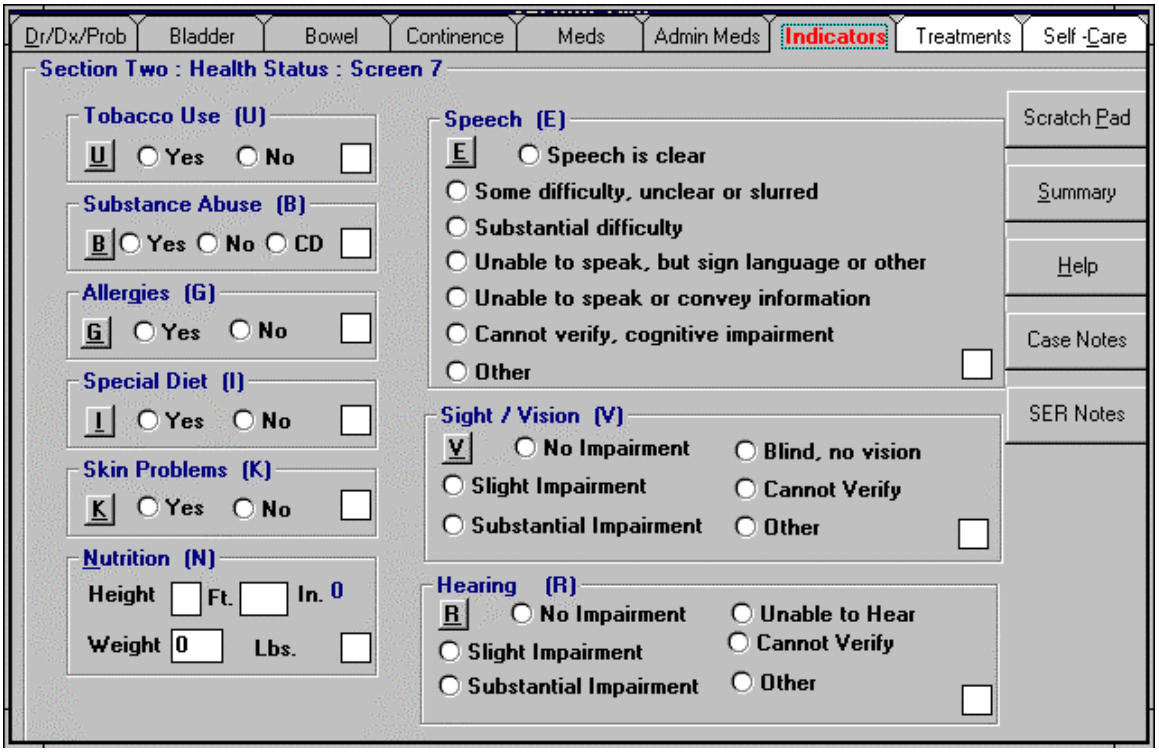

Dr/Dx/Prob
Bladder
Bowel
Continence
Meds
Admin Meds
Indicators
Treatments
Self -Care
Section Two : Health Status : Screen 2
Within the last 14 days, what is the individual's pattern of bowel and bladder control? Determine this through discussion with the individual and through collateral contacts with caregivers, family members and others who know the individual.
Scratch Pad
Summary
Help
Case Notes
SER Notes
Bladder Control: (B)
B
Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g. catheter) or continence programs, if employed.
Continent. Complete control; or control achieved by care that involves timed toileting, prompted voiding, reminders or indewlling catheter that does not leak.
*Note: If dribbles, volume is insufficient to soak through underpants.
Usually continent. Incontinent episodes once a week, or less.
Occasionally incontinent, two or three times a week, but not daily.
Frequently incontinent, daily incontinence with some control present.
Incontinent, multiple daily episodes.
Individuals bladder continence has changed as compared to status of 90 days ago (or since last assessed, if less than 90 days)
No Change
Improved
Deteriorated

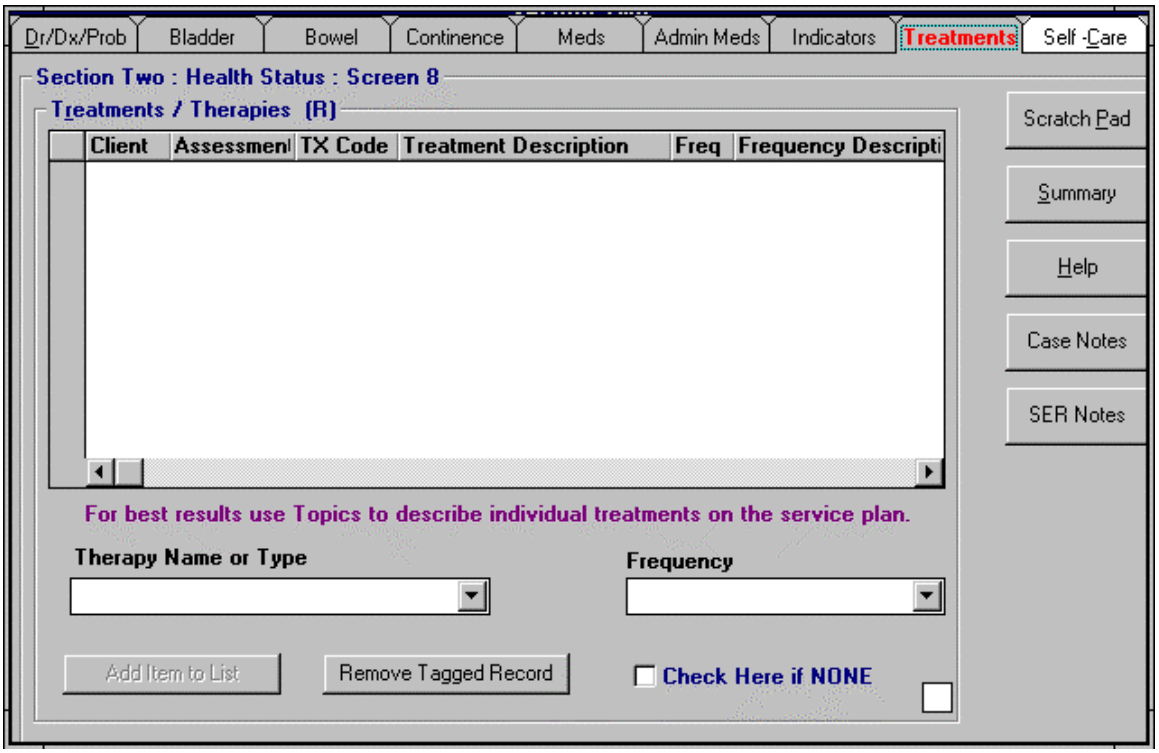

Dr/Dx/Prob
Bladder
Bowel
Continence
Meds
Admin Meds
Indicators
Treatments
Self -Care
Section Two : Health Status : Screen 3
Scratch Pad
Summary
Help
Case Notes
SER Notes
Bowel Control. (W)
W
With appliance or bowel continence progams, if employed.
Continent. Complete control; or control that includes use of ostomy-device such as colostomy or ileostomy that does not leak, or bowel program, if employed.
Usually Continent. incontinent episodes less than weekly.
Occasionally Incontinent, once a week.
Frequently Incontinent, 2 - 3 times per week
Incontinent, had inadequate control all (or almost all) of the time.
Bowel Elimination Pattern in last 14 days.
Bowel elimination pattern regular-at least one movement every 3 days.
Constipation
Diarrhea
Fecal Impaction
None of these.
Individuals bowel continence has changed as compared to status of 90 days ago (or since last assessment, if less than 90 days).
No Change
Improved
Deteriorated

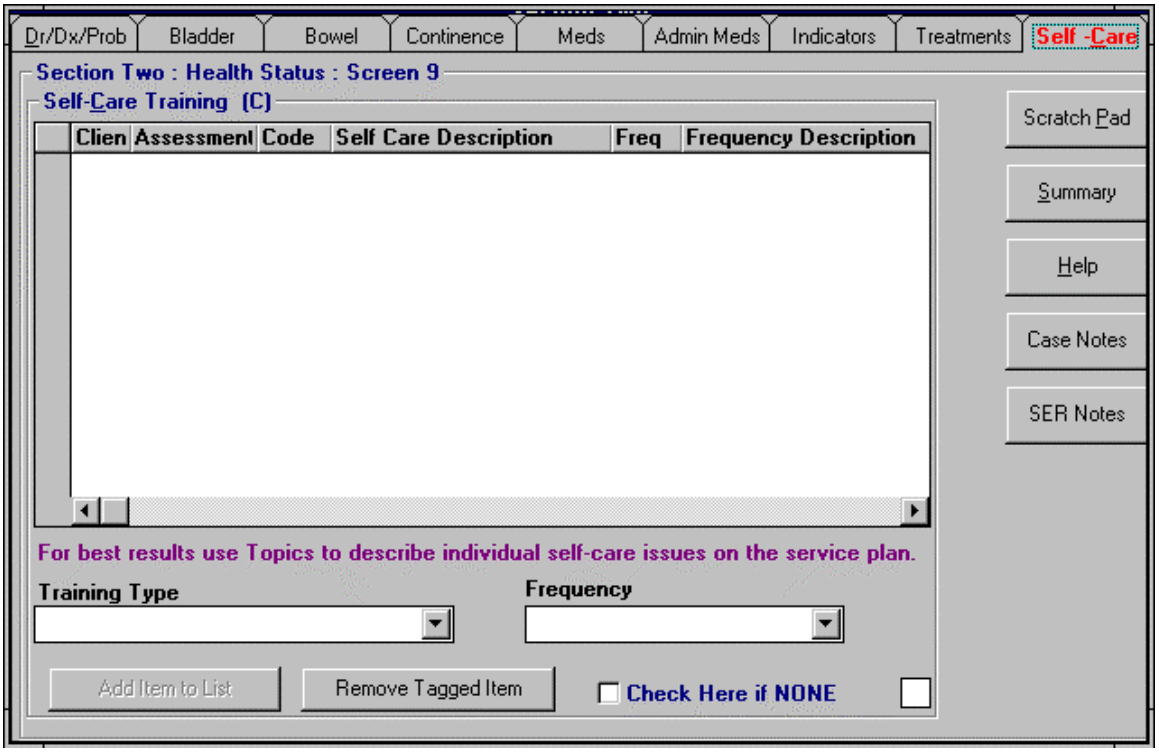

Dr/Dx/Prob
Bladder
Bowel
Continence
Meds
Admin Meds
Indicators
Treatments
Self -Care
Section Two : Health Status : Screen 4
Appliances and Programs used in last 14 days.
Any scheduled toileting plan (includes Bladder retraining program)
Did not use toilet room, bedside commode, urinal or bedpan in last 14 days
Bowel Program
Pads/briefs used
External (condom) catheter
Enemas/irrigation
Indwelling catheter
Ostomy present
Intermittent catheter
None of these.
Individual's management of bowel and bladder supplies (pads, briefs, ostomy, catheter) in last 14 days.
Individual doesn't need or use supplies or appliances.
Individual uses supplies or appliances independently
Individual uses supplies or appliances and is dry and clean with such: requires assistance with the supplies or appliances.
Individual uses supplies or appliances, has leakage onto skin with such, necessitating cleansing/assistance.
Individual does not use supplies or appliances, and has leakage onto skin.
Scratch Pad
Summary
Help
Case Notes
SER Notes


Dr/Dx/Prob
Bladder
Bowel
Continence
Meds
Admin Meds
Indicators
Treatments
Self -Care
Section Two : Health Status : Screen 5
Prescribed Medications (R)
Medication Name
Dosage
Frequency
Route
Medication Name
Dosage
Frequency
Route
Add Item To List
Remove Tagged Item(s)
Check Here if NONE
Total 0
Hint: To clear the entire Meds list, click on 'Check Here if None'
Over the Counter Medications (O)
Describe Usage
Check Here if NONE
Contra indicated issues related to Medications
Describe Relevant Issues and/or Possible Problems Below
Red Flags
?? To Ask
Scratch Pad
Summary
Help
Case Notes
SER Notes

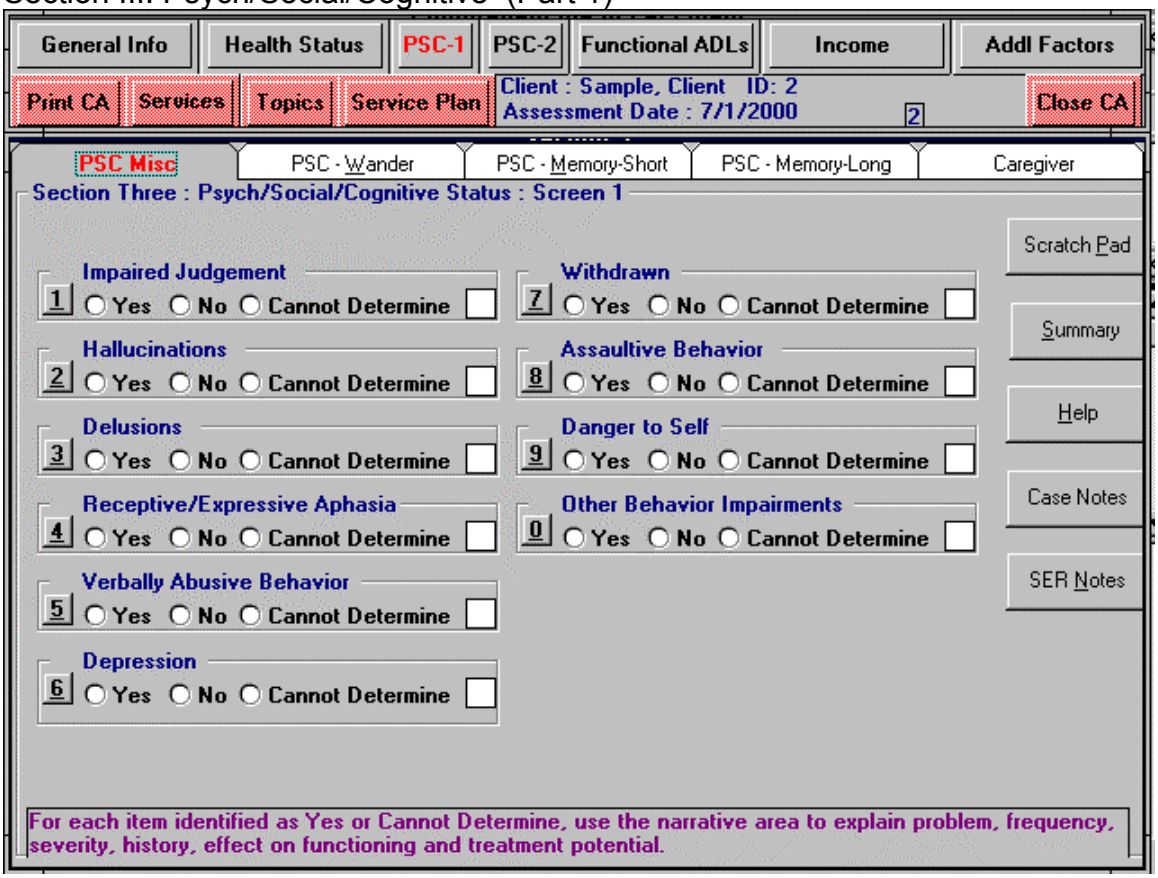

Dr/Dx/Prob
Bladder
Bowel
Continence
Meds
Admin Meds
Indicators
Treatments
Self -Care
Section Two : Health Status : Screen 6
Level of Assistance Required to Take Medications
1. Independent.
3. Assistance Required
5. Must be administered to person
Individual remembers to take medications as prescribed, manages own administration independently.
Name and relationship to client of peson providing medication assistance
Last Name
First Name
Relation to Client
Needs Professional for Medication Preparation/Administration ? Yes No
Pharmacy Information
Primary Pharmacy Name
Pharmacy Phone Number
Scratch Pad
Summary
Help
Case Notes
SER Notes

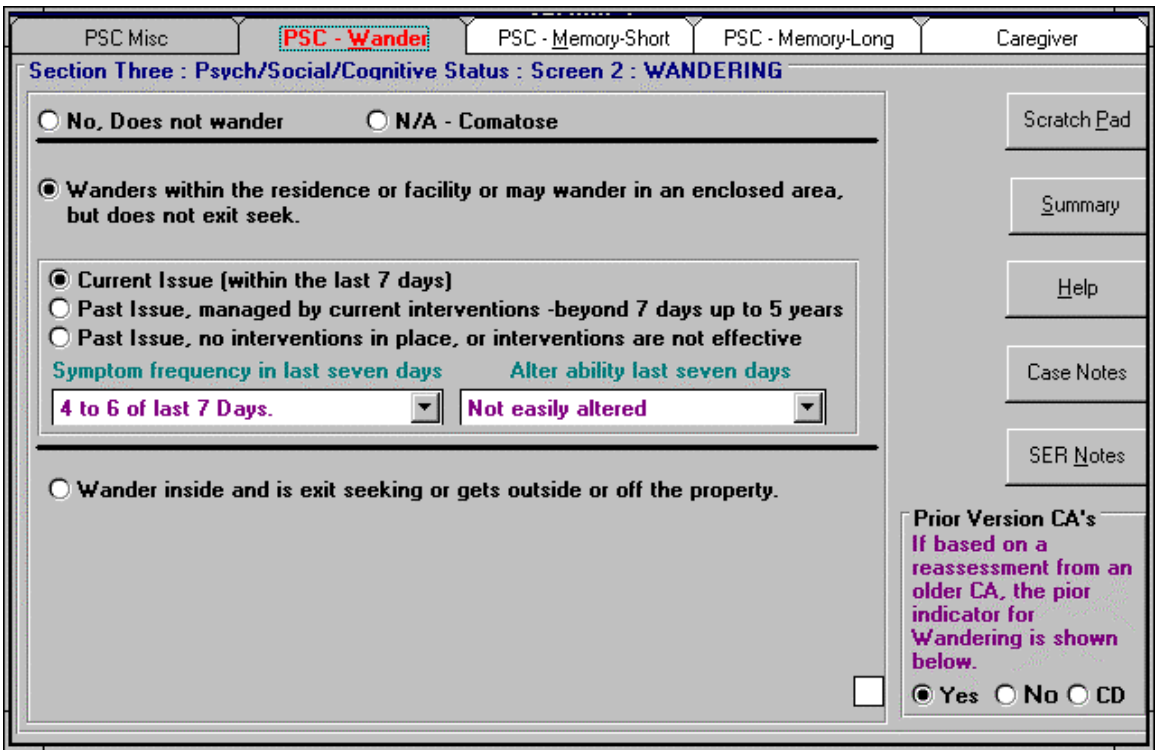

Dr/Dx/Prob
Bladder
Bowel
Continence
Meds
Admin Meds
Indicators
Treatments
Self -Care
Section Two : Health Status : Screen 7
Tobacco Use (U)
U Yes No
Substance Abuse (B)
B Yes No CD
Allergies (G)
G Yes No
Special Diet (I)
I Yes No
Skin Problems (K)
K Yes No
Nutrition (N)
Height Ft. In. 0
Weight 0 Lbs.
Speech (E)
E Speech is clear
Some difficulty, unclear or slurred
Substantial difficulty
Unable to speak, but sign language or other
Unable to speak or convey information
Cannot verify, cognitive impairment
Other
Sight / Vision (V)
V No Impairment
Slight Impairment
Substantial Impairment
Blind, no vision
Cannot Verify
Other
Hearing (R)
R No Impairment
Slight Impairment
Substantial Impairment
Unable to Hear
Cannot Verify
Other
Scratch Pad
Summary
Help
Case Notes
SER Notes

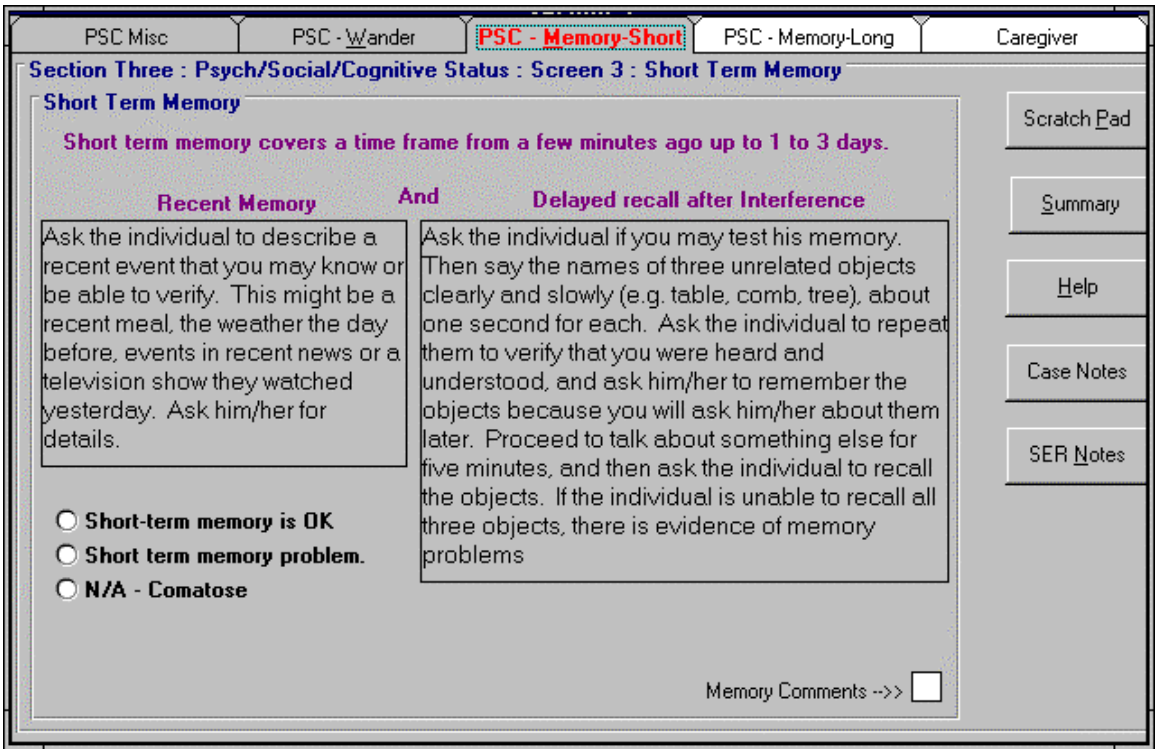

Dr/Dx/Prob
Bladder
Bowel
Continence
Meds
Admin Meds
Indicators
Treatments
Self -Care
Section Two : Health Status : Screen 8
Treatments / Therapies (R)
Client
Assessmen
TX Code
Treatment Description
Freq
Frequency Descripti
Scratch Pad
Summary
Help
Case Notes
SER Notes
For best results use Topics to describe individual treatments on the service plan.
Therapy Name or Type
Frequency
Add Item to List
Remove Tagged Record
Check Here if NONE

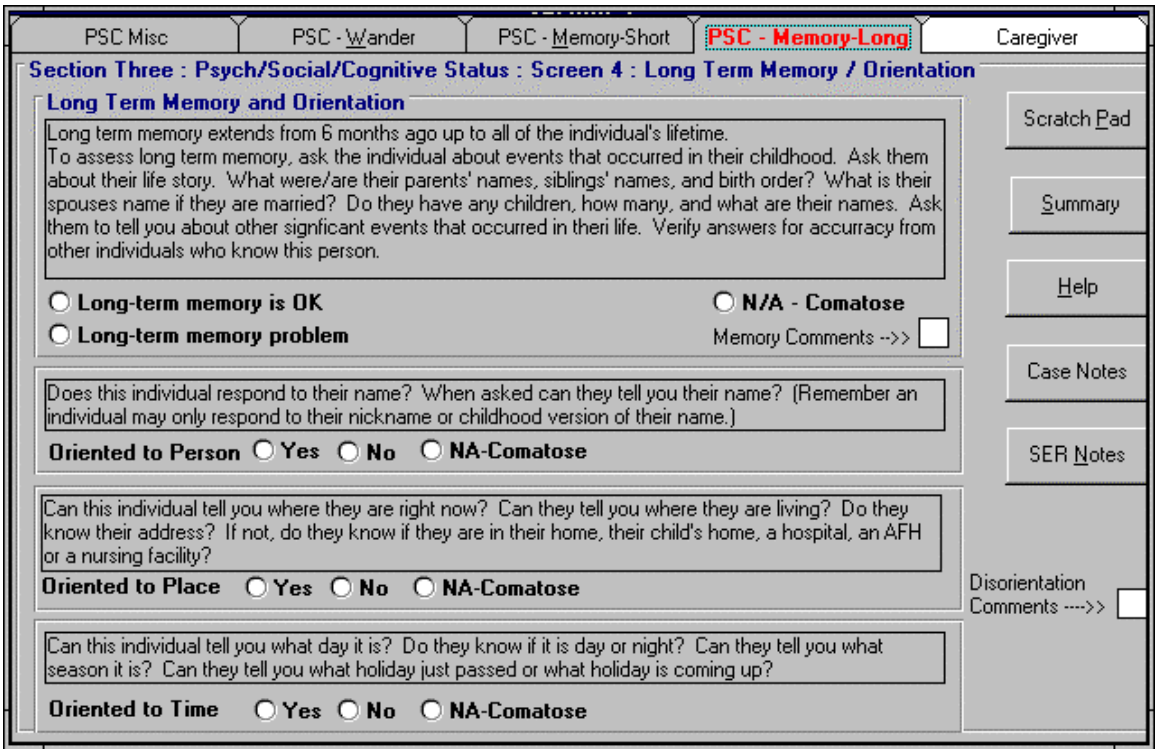

Dr/Dx/Prob
Bladder
Bowel
Continence
Meds
Admin Meds
Indicators
Treatments
Self -Care
Section Two : Health Status : Screen 9
Self-Care Training (C)
Clien
Assessment
Code
Self Care Description
Freq
Frequency Description
Scratch Pad
Summary
Help
Case Notes
SER Notes
For best results use Topics to describe individual self-care issues on the service plan.
Training Type
Frequency
Add Item to List
Remove Tagged Item
Check Here if NONE

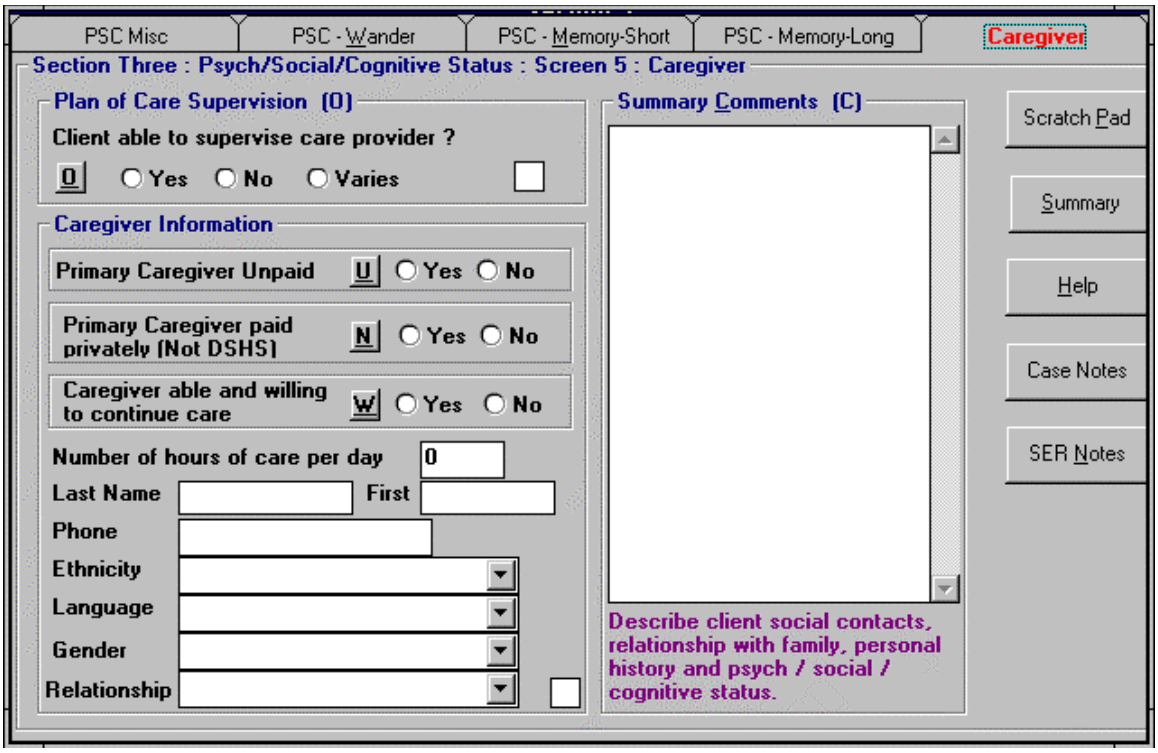
Section III. Psych/Social/Cognitive (Part 1)



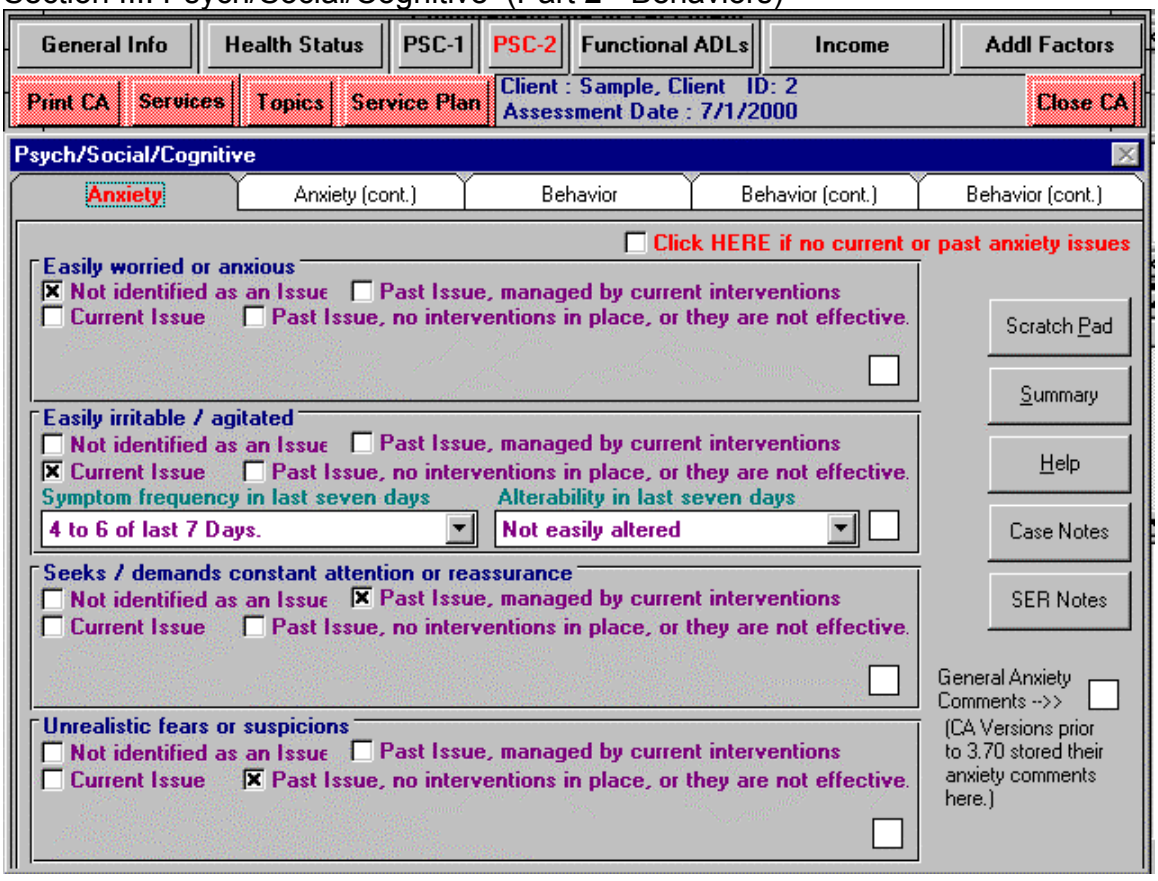


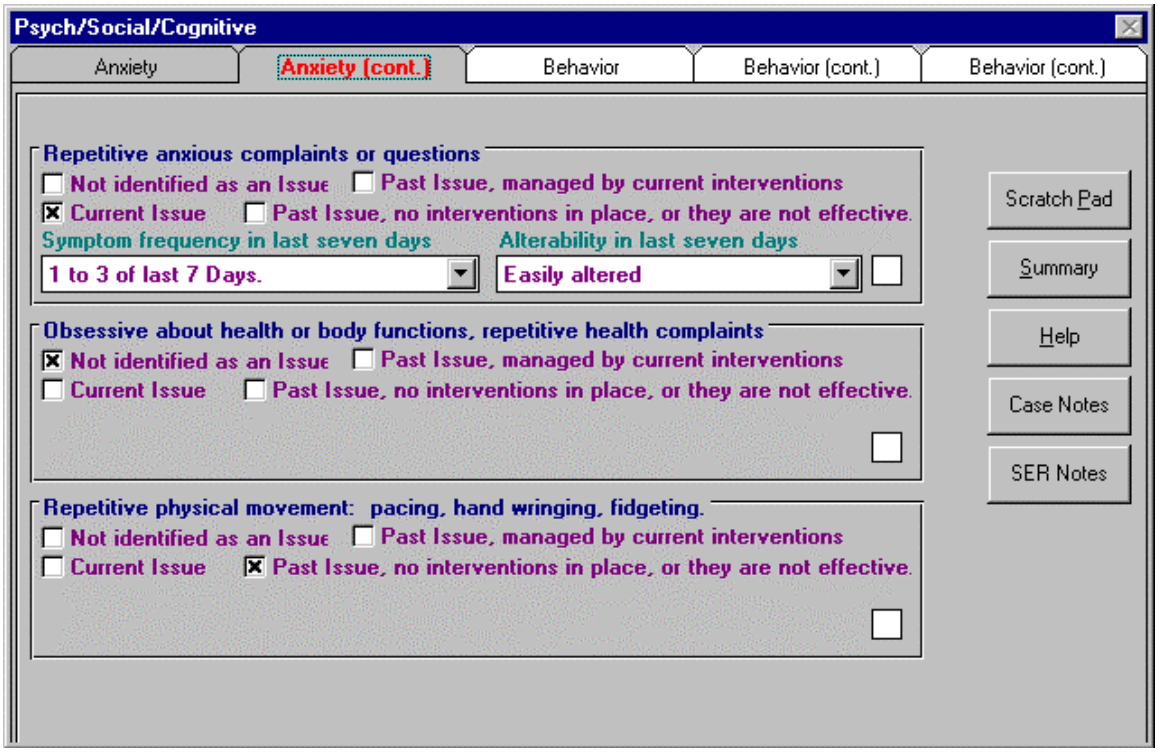

PSC Misc
PSC - Wander
PSC - Memory-Short
PSC - Memory-Long
Caregiver
Section Three : Psych/Social/Cognitive Status : Screen 3 : Short Term Memory
Short Term Memory
Short term memory covers a time frame from a few minutes ago up to 1 to 3 days.
Recent Memory
And
Delayed recall after Interference
Ask the individual to describe a recent event that you may know or be able to verify. This might be a recent meal, the weather the day before, events in recent news or a television show they watched yesterday. Ask him/her for details.
Ask the individual if you may test his memory. Then say the names of three unrelated objects clearly and slowly (e.g. table, comb, tree), about one second for each. Ask the individual to repeat them to verify that you were heard and understood, and ask him/her to remember the objects because you will ask him/her about them later. Proceed to talk about something else for five minutes, and then ask the individual to recall the objects. If the individual is unable to recall all three objects, there is evidence of memory problems
Short-term memory is OK
Short term memory problem.
N/A - Comatose
Memory Comments -->>
Scratch Pad
Summary
Help
Case Notes
SER Notes

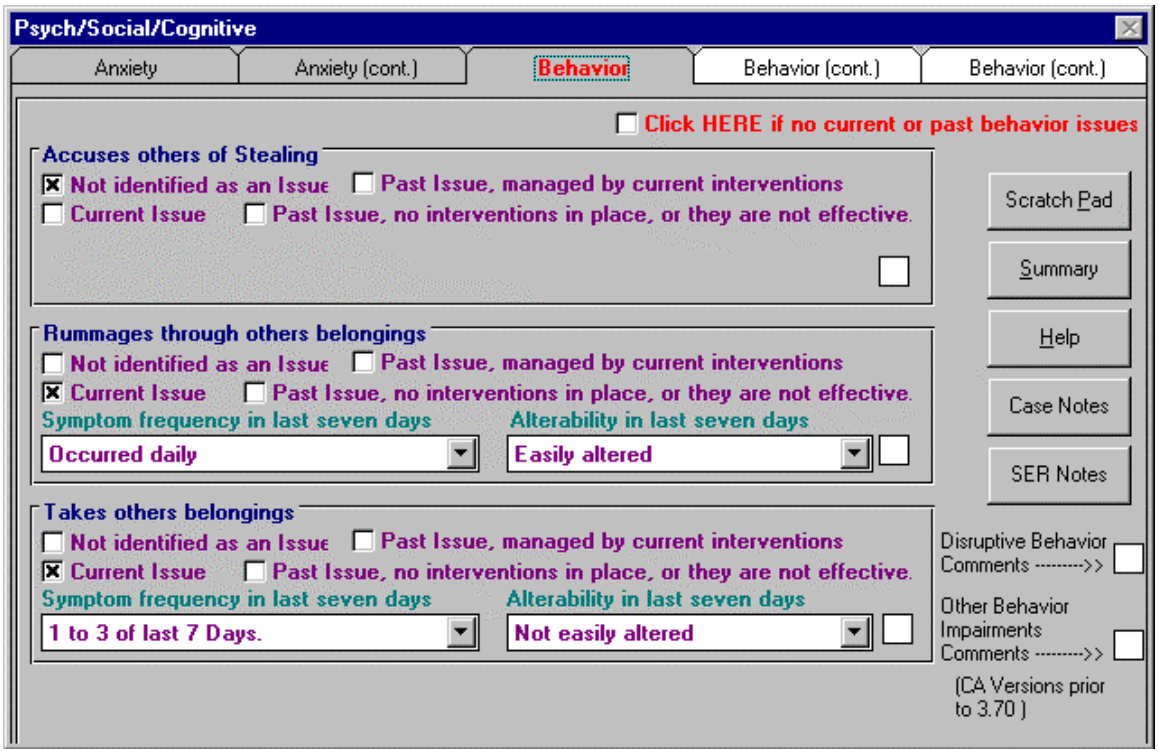

PSC Misc
PSC - Wander
PSC - Memory-Short
PSC - Memory-Long
Caregiver
Section Three : Psych/Social/Cognitive Status : Screen 4 : Long Term Memory / Orientation
Long Term Memory and Orientation
Long term memory extends from 6 months ago up to all of the individual's lifetime.
To assess long term memory, ask the individual about events that occurred in their childhood. Ask them about their life story. What were/are their parents' names, siblings' names, and birth order? What is their spouses name if they are married? Do they have any children, how many, and what are their names. Ask them to tell you about other signficant events that occurred in theri life. Verify answers for accurracy from other individuals who know this person.
Long-term memory is OK
Long-term memory problem
N/A - Comatose
Memory Comments -->>
Does this individual respond to their name? When asked can they tell you their name? (Remember an individual may only respond to their nickname or childhood version of their name.)
Oriented to Person Yes No NA-Comatose
Can this individual tell you where they are right now? Can they tell you where they are living? Do they know their address? If not, do they know if they are in their home, their child's home, a hospital, an AFH or a nursing facility?
Oriented to Place Yes No NA-Comatose
Disorientation Comments ---->>
Can this individual tell you what day it is? Do they know if it is day or night? Can they tell you what season it is? Can they tell you what holiday just passed or what holiday is coming up?
Oriented to Time Yes No NA-Comatose
Scratch Pad
Summary
Help
Case Notes
SER Notes

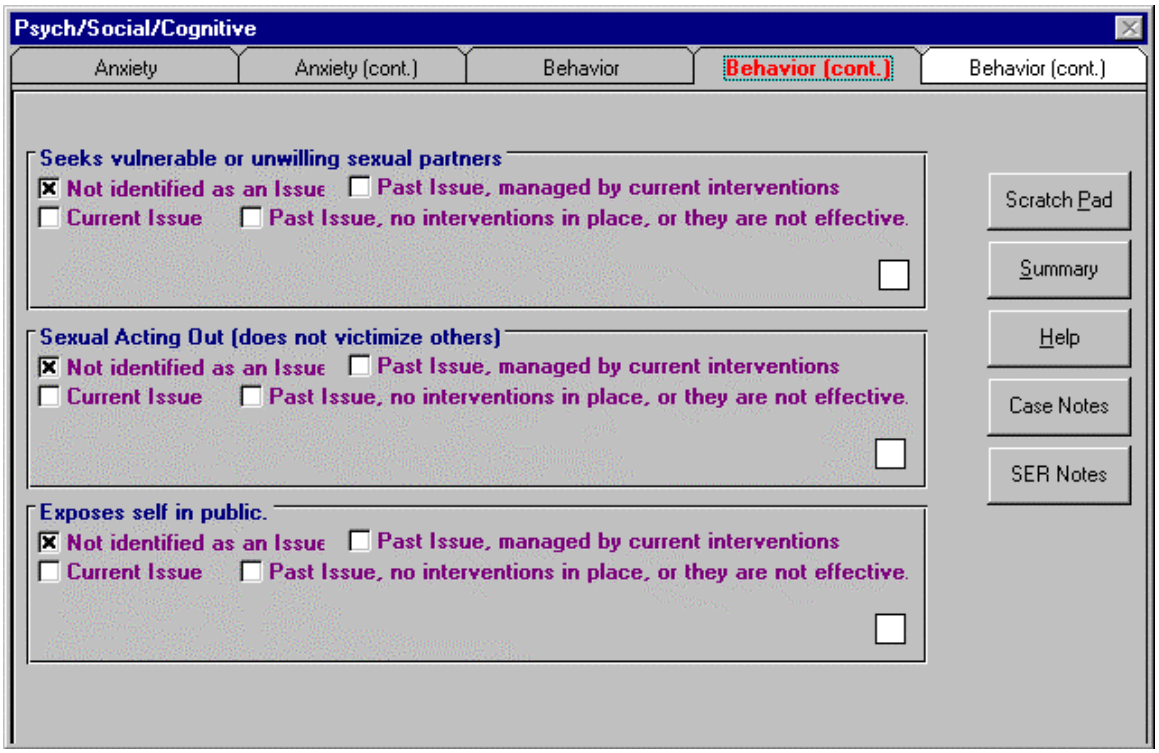


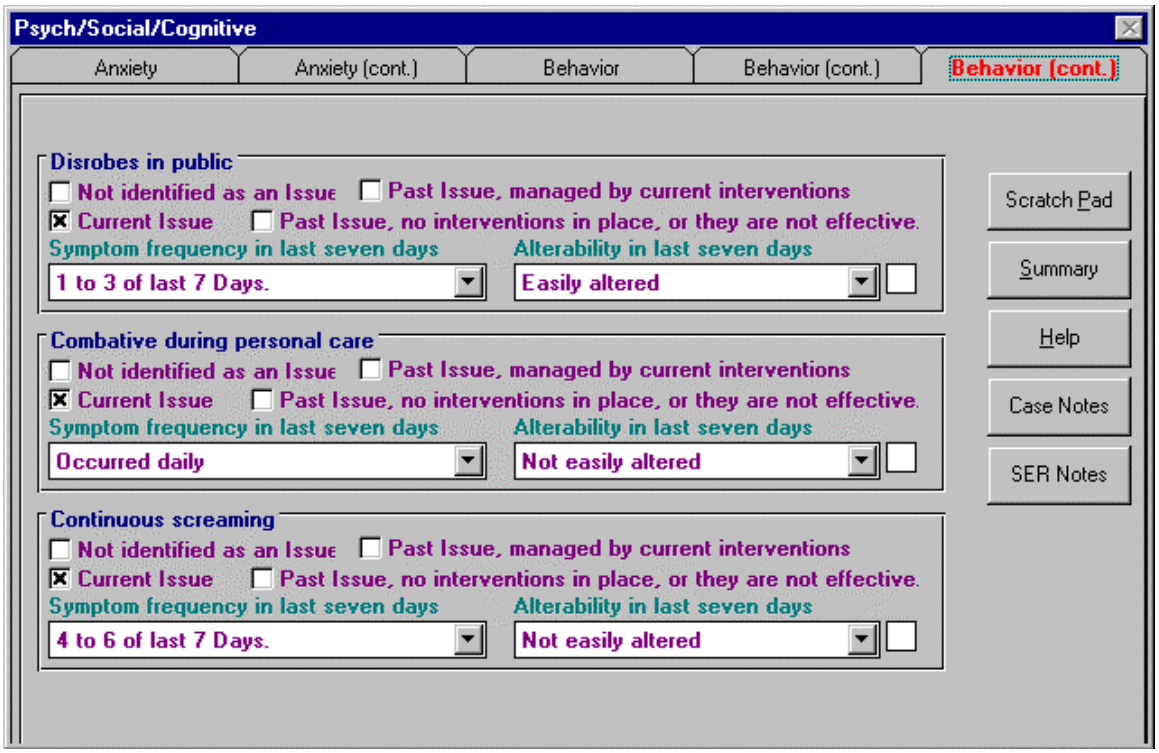
Section III. Psych/Social/Cognitive (Part 2 - Behaviors)



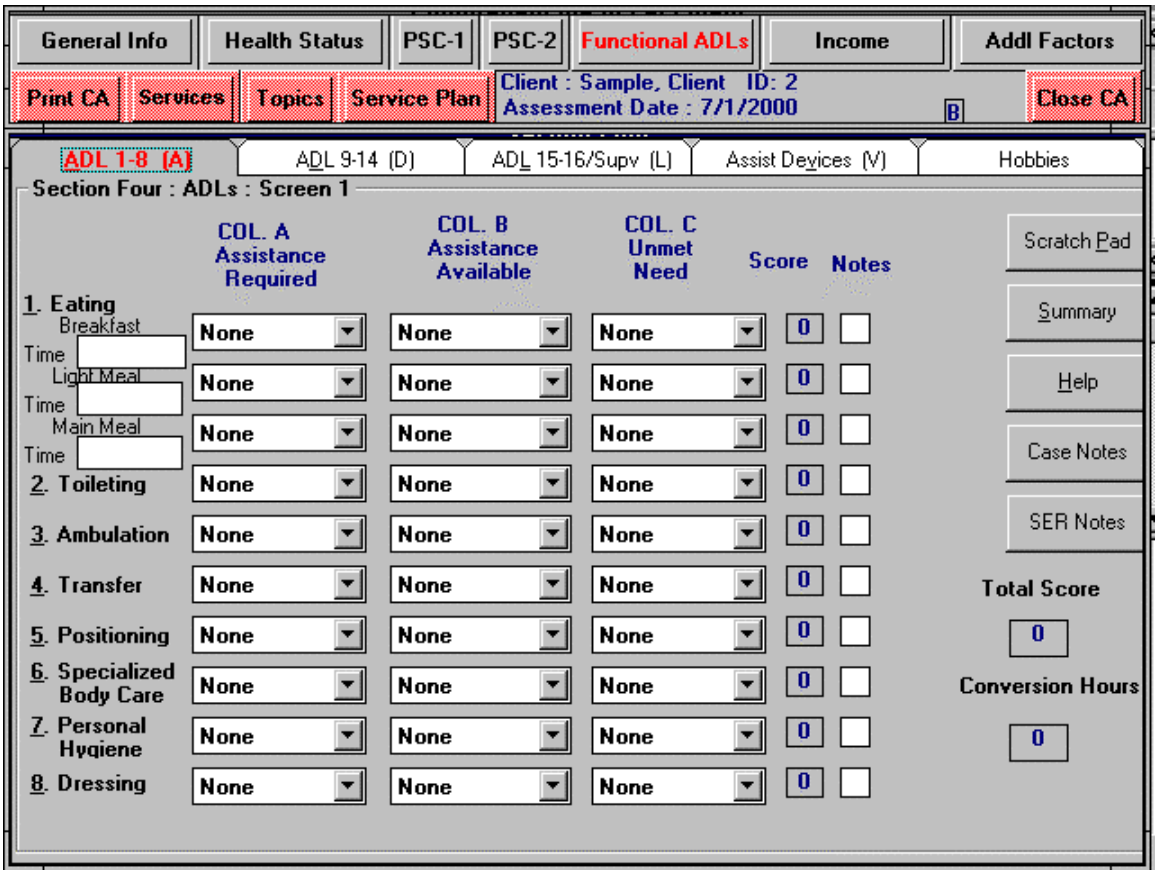

Psych/Social/Cognitive
Anxiety
Anxiety (cont.)
Behavior
Behavior (cont.)
Behavior (cont.)
Repetitive anxious complaints or questions
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Symptom frequency in last seven days
1 to 3 of last 7 Days.
Alterability in last seven days
Easily altered
Obsessive about health or body functions, repetitive health complaints
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Repetitive physical movement: pacing, hand wringing, fidgeting.
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Scratch Pad
Summary
Help
Case Notes
SER Notes

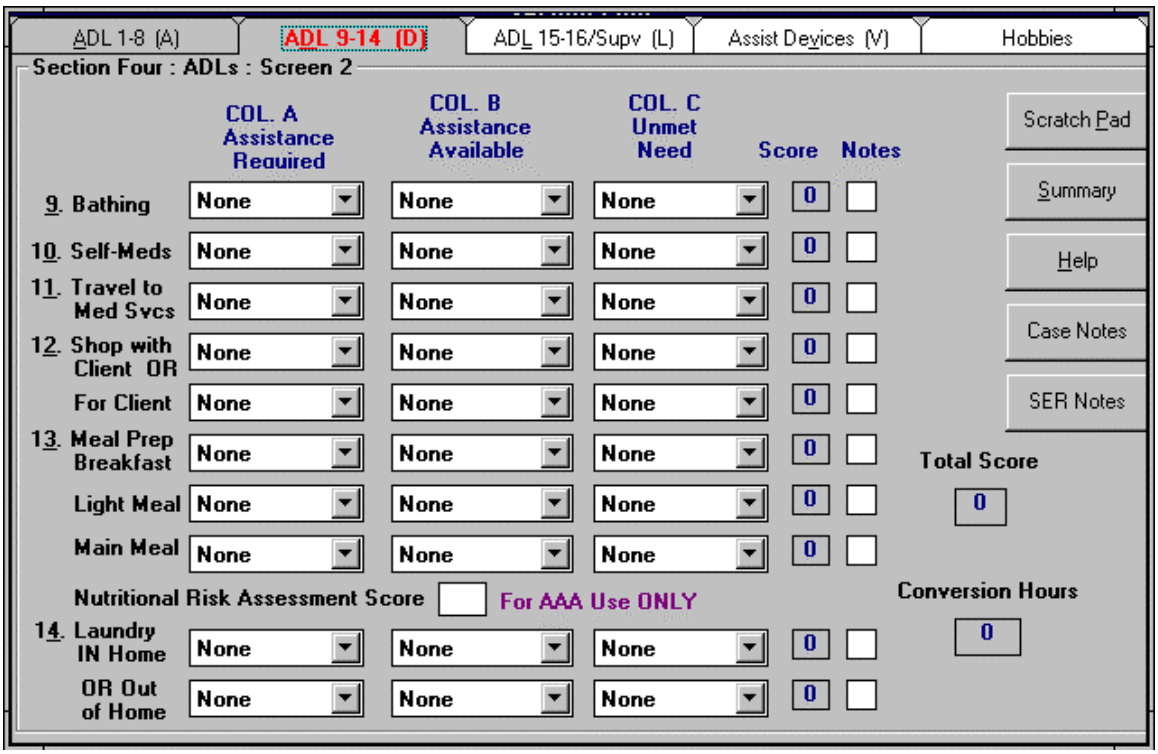

Psych/Social/Cognitive
Anxiety
Anxiety (cont.)
Behavior
Behavior (cont.)
Behavior (cont.)
Click HERE if no current or past behavior issues
Accuses others of Stealing
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Rummages through others belongings
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Symptom frequency in last seven days
Occurred daily
Alterability in last seven days
Easily altered
Takes others belongings
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Symptom frequency in last seven days
1 to 3 of last 7 Days.
Alterability in last seven days
Not easily altered
Scratch Pad
Summary
Help
Case Notes
SER Notes
Disruptive Behavior Comments -------->>
Other Behavior Impairments Comments -------->>
(CA Versions prior to 3.70)

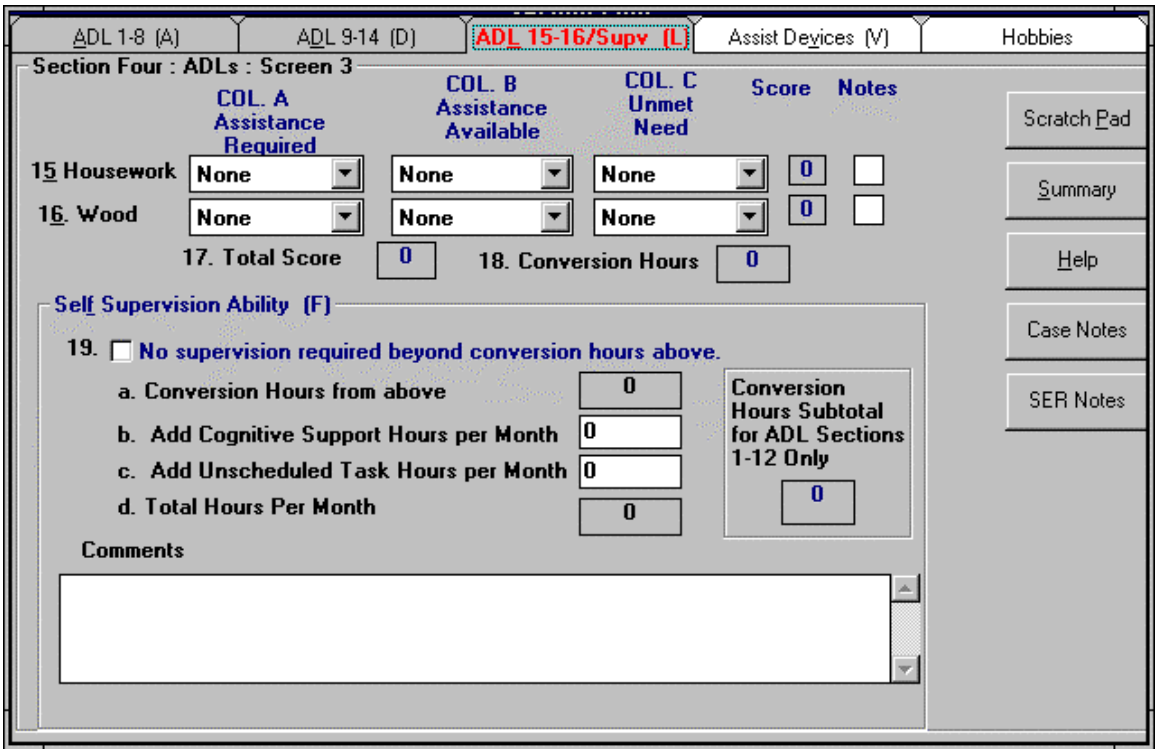

Psych/Social/Cognitive
Anxiety
Anxiety (cont.)
Behavior
Behavior (cont.)
Behavior (cont.)
Seeks vulnerable or unwilling sexual partners
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Sexual Acting Out (does not victimize others)
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Exposes self in public.
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Scratch Pad
Summary
Help
Case Notes
SER Notes

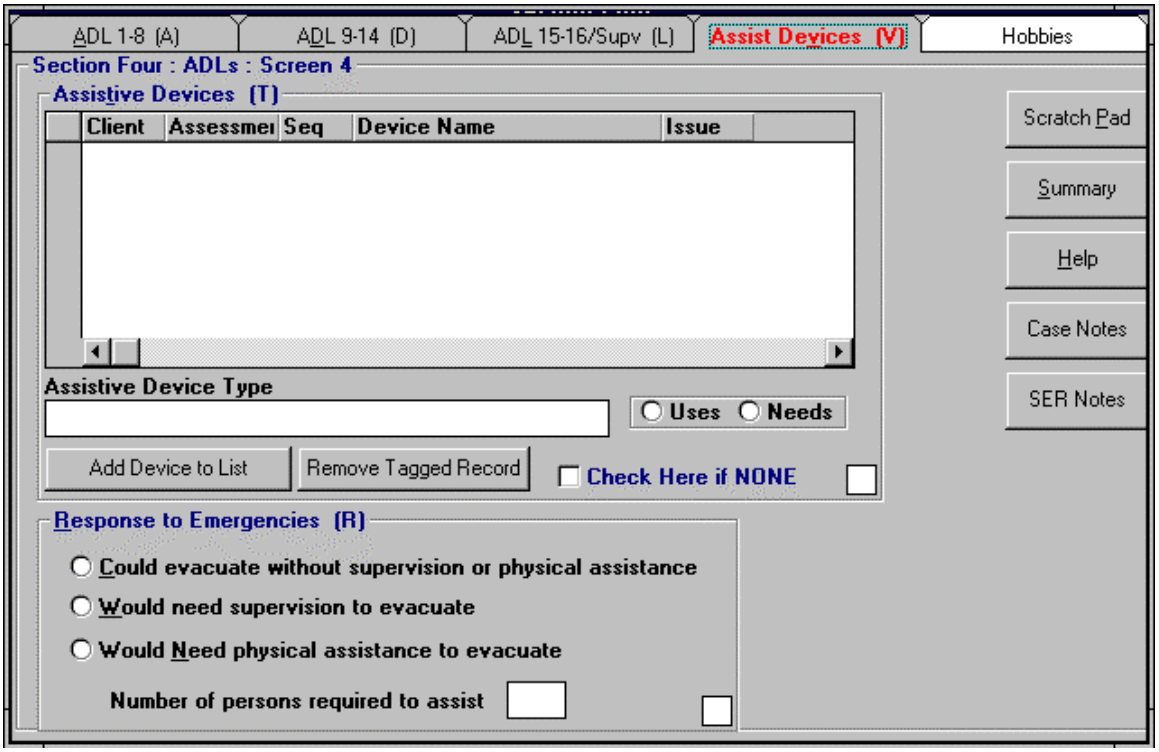

Psych/Social/Cognitive
Anxiety
Anxiety (cont.)
Behavior
Behavior (cont.)
Behavior (cont.)
Disrobes in public
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Symptom frequency in last seven days
1 to 3 of last 7 Days.
Alterability in last seven days
Easily altered
Combative during personal care
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Symptom frequency in last seven days
Occurred daily
Alterability in last seven days
Not easily altered
Continuous screaming
Not identified as an Issue
Past Issue, managed by current interventions
Current Issue
Past Issue, no interventions in place, or they are not effective.
Symptom frequency in last seven days
4 to 6 of last 7 Days.
Alterability in last seven days
Not easily altered
Scratch Pad
Summary
Help
Case Notes
SER Notes

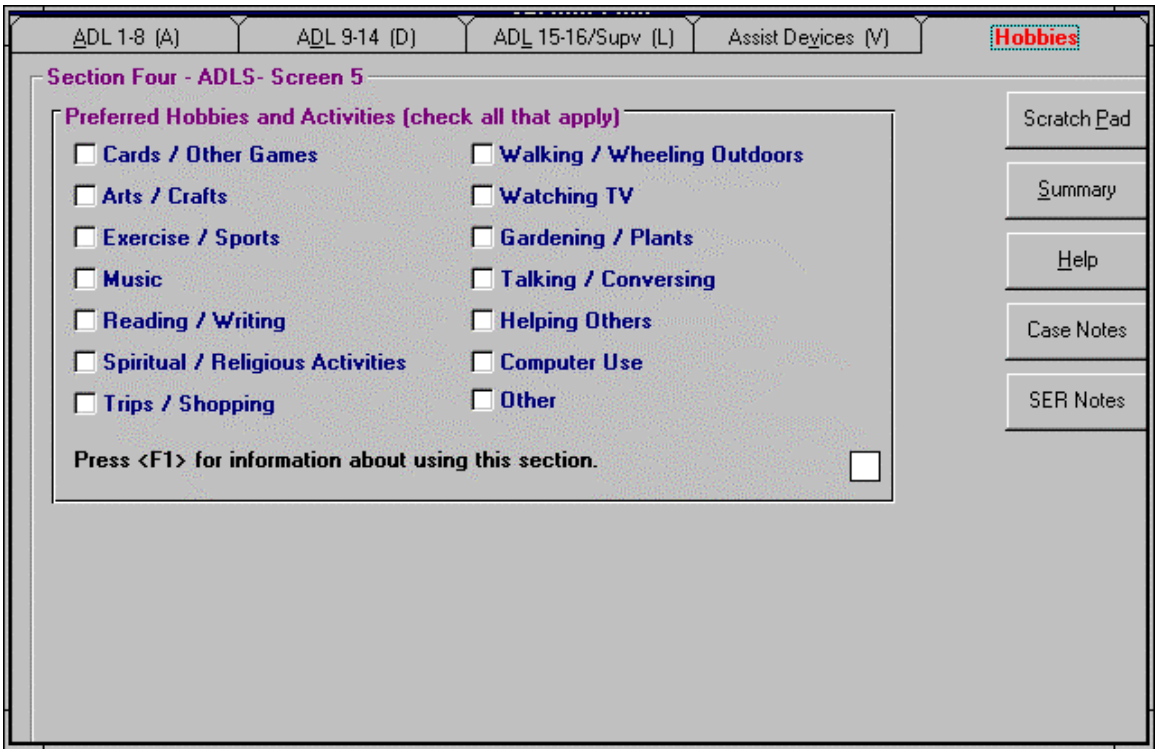
Section IV. – Functional ADL's



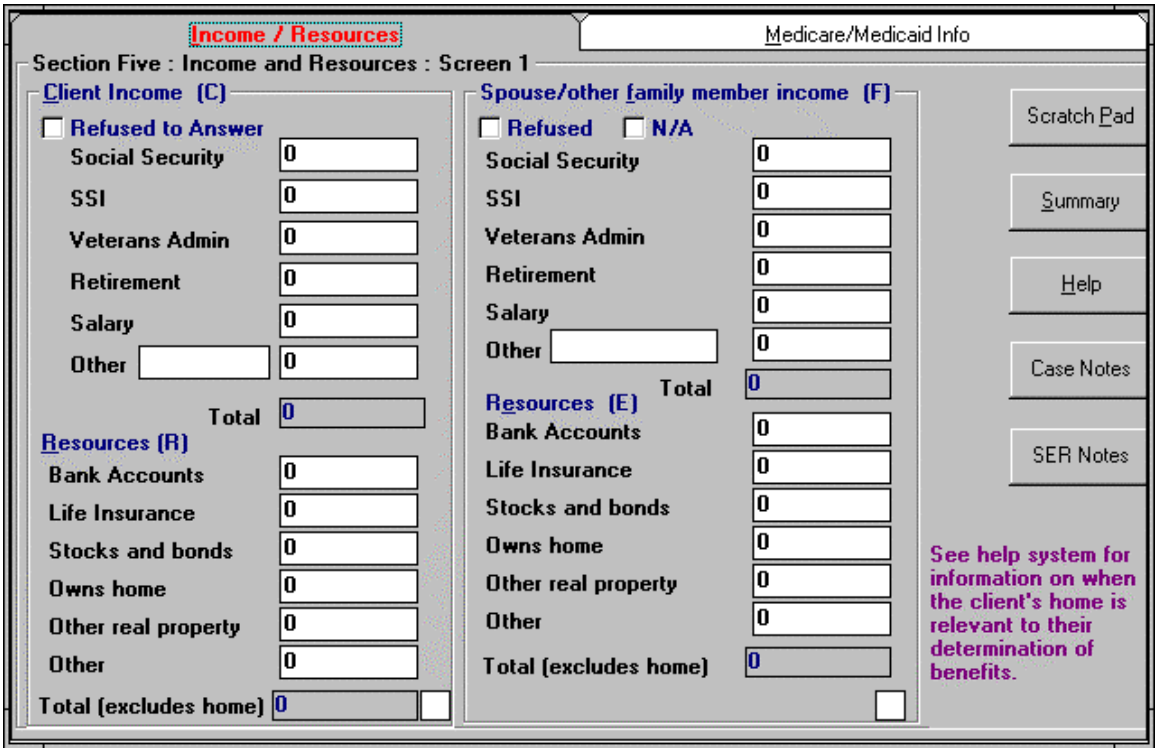


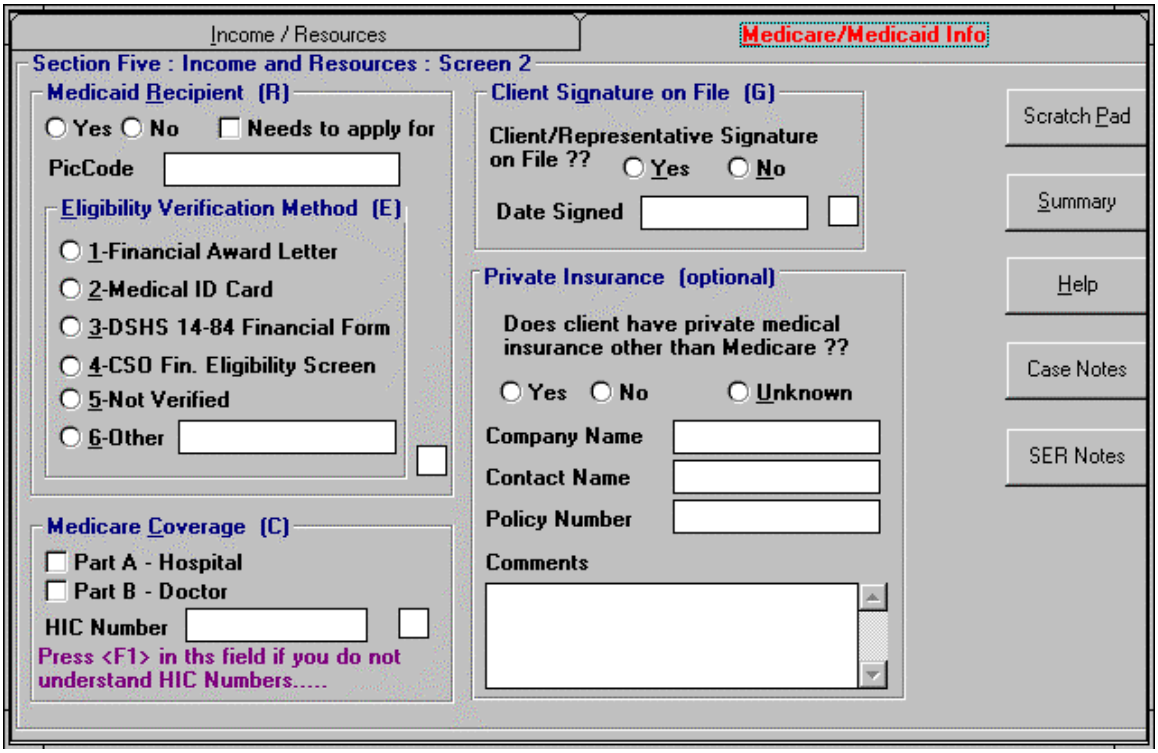

ADL 1-8 (A)
ADL 9-14 (D)
ADL 15-16/Supv (L)
Assist Devices (V)
Hobbies
Section Four : ADLs : Screen 3
COL. A Assistance Required
COL. B Assistance Available
COL. C Unmet Need
Score
Notes
15 Housework
16. Wood
None
0
17. Total Score
18. Conversion Hours
Self Supervision Ability (F)
19. No supervision required beyond conversion hours above.
a. Conversion Hours from above
b. Add Cognitive Support Hours per Month
c. Add Unscheduled Task Hours per Month
d. Total Hours Per Month
Conversion Hours Subtotal for ADL Sections 1-12 Only
Comments
Scratch Pad
Summary
Help
Case Notes
SER Notes


ADL 1-8 (A)
ADL 9-14 (D)
ADL 15-16/Supv (L)
Assist Devices (V)
Hobbies
Section Four : ADLs : Screen 4
Assistive Devices (T)
Client
Assessmer
Seq
Device Name
Issue
Assistive Device Type
Uses
Needs
Add Device to List
Remove Tagged Record
Check Here if NONE
Response to Emergencies (R)
Could evacuate without supervision or physical assistance
Would need supervision to evacuate
Would Need physical assistance to evacuate
Number of persons required to assist
Scratch Pad
Summary
Help
Case Notes
SER Notes

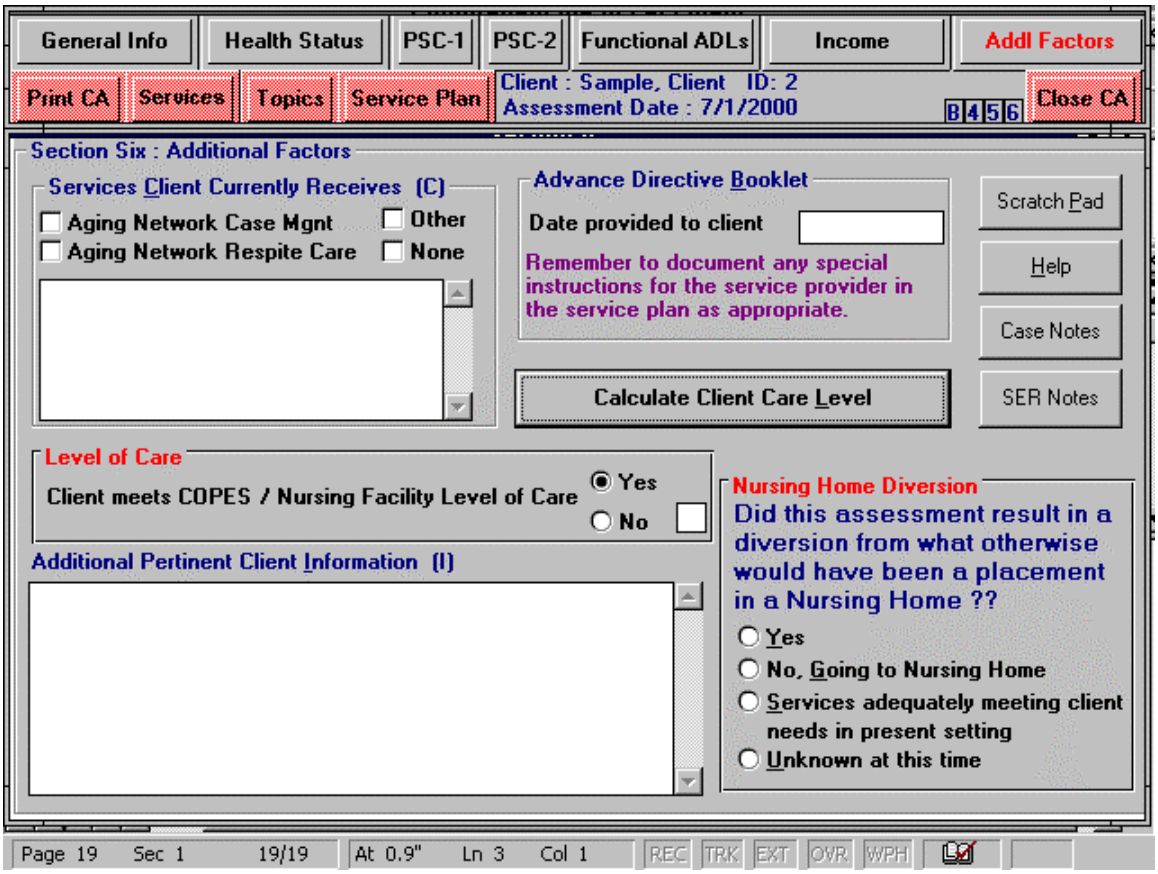


Section V. – Income





Section VI. – Additional Factors



Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
DIVISION OF CHILDREN AND FAMILY SERVICES (DCFS)
MEDICAID PERSONAL CARE (MPC)

COMPREHENSIVE ASSESSMENT (CHILD)

SECTION 1. GENERAL INFORMATION

1. CHILD'S LAST NAME | FIRST NAME | MIDDLE INITIAL

2. ASSESSMENT DATE

3. COMMUNITY SERVICES OFFICE (CSO) NUMBER

4. BIRTH DATE

5. DDD OR DCFS CASE NUMBER

6. SEX
☐ 1 Male ☐ 2 Female

7. STREET ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)

GIVE DIRECTIONS IF NECESSARY

8. EMERGENCY CONTACT NAME

TELEPHONE NUMBER (INCLUDE AREA CODE)

RELATIONSHIP TO CHILD

STREET ADDRESS

CITY | STATE | ZIP CODE

9. RACE/ETHNICITY
Enter code:

10. SPANISH/HISPANIC
Enter code:

11. PRIMARY LANGUAGE
Enter code:

12. SPEAKS ENGLISH
☐ 1 Yes ☐ 2 Limited ☐ 3 No

13. UNDERSTANDS ENGLISH
☐ 1 Yes ☐ 2 Limited ☐ 3 No

14. INTERPRETER REQUIRED
☐ 1 No
☐ 2 Yes: ☐ Family ☐ Child ☐ Provider

15. MEDICAID RECIPIENT
☐ 1 No ☐ 2 Yes

ELIGIBILITY VERIFICATION METHOD:
☐ SSPS authorization for medical (for DCFS foster children only)
☐ Medical Identification Card
☐ Financial/Social Services Communication, DSHS 14-084(X)
☐ ACES/Barcode
☐ Other, specify method:

If answer is "No," do not proceed with assessment for MPC services. **Child is not eligible.**

16. ASSESSMENT TYPE
☐ 1 Initial ☐ 2 Full reassessment

17. ASSESSMENT PLACE
☐ 1 Home
☐ 2 Child foster home
☐ 3 Group care
☐ 4 Nursing facility
☐ 5 Hospital
☐ Other

Specify the name of the assessment place:

18. USUAL RESIDENCE
☐ 1 Parent's home
☐ 2 Relative's home
☐ 3 Other's home
☐ 4 Child foster home
☐ 5 Nursing facility
☐ 6 Group home, DDD/DCFS
☐ 7 State institution, DDD
☐ 8 Psychiatric hospital
☐ 9 No residence
☐ 99 Other

19. INFORMANT INFORMATION
Informant used as primary source of information.

NAME

TELEPHONE NUMBER (INCLUDE AREA CODE)

RELATIONSHIP TO CHILD

20. OTHER ASSESSMENT PARTICIPANTS

NAME	RELATIONSHIP	TELEPHONE NUMBER

21. PRESENTING ISSUES

22. ASSESSOR'S NAME

23. OFFICE IDENTIFICATION

24. TELEPHONE NUMBER (INCLUDE AREA CODE)

25. WORKER IDENTIFICATION

1. CHILD'S LAST NAME	FIRST NAME	MIDDLE INITIAL	ASSESSMENT DATE

SECTION 2. HEALTH STATUS

1. PRIMARY PHYSICIAN'S NAME

2. TELEPHONE NUMBER (INCLUDE AREA CODE)

3. CURRENT DIAGNOSES AND SOURCE OF INFORMATION

4. PERTINENT HISTORY (PHYSICAL AND MENTAL HEALTH)

5. BLADDER CONTROL
- ☐ 1 Continent
- ☐ 2 Incontinent; frequency:
- ☐ 3 Urostomy or catheter

6. BOWEL CONTROL
- ☐ 1 Continent
- ☐ 2 Incontinent; frequency:
- ☐ 3 Colostomy

Comments:

7. MEDICATIONS (LIST ALL PRESCRIBED MEDICATIONS)

☐ **Check here if no prescribed medications.**

PRESCRIBED MEDICATIONS (NAME AND DOSAGE)

8. Total number of prescribed medications:

COMMENTS REGARDING MEDICATION USE

9. OVER-THE-COUNTER (OTC) MEDICATIONS/HOME REMEDIES

☐ **Check here if none.**

Comments:

1. CHILD'S LAST NAME	FIRST NAME	MIDDLE INITIAL	ASSESSMENT DATE

SECTION 2. HEALTH STATUS (CONTINUED)

10. ALLERGIES

☐ 1 Yes ☐ 2 No ☐ 3 Unknown

List:

11. COMMUNICATION SKILLS/SENSORY IMPAIRMENTS

A. SPEECH

☐ 1 Speech is clear
☐ 2 Has some difficulty speaking; speech is unclear or slurred
☐ 3 Has substantial difficulty speaking; speech is not understandable most of the time
☐ 4 Unable to speak but conveys and/or receives information through other means (sign language, writing, touch, etc.)
☐ 5 Unable to speak or convey/receive information
☐ 6 Cannot verify because of severe cognitive impairment (coma, brain damage, etc.)
☐ 7 Other:

B. SIGHT

☐ 1 No impairment or impairment is compensated for with use of corrective lenses
☐ 2 Slight impairment, even with corrective lenses
☐ 3 Substantive impairment, even with corrective lenses; includes legally blind (20/200 not correctable)
☐ 4 Blind; no vision
☐ 5 Cannot verify because of severe impairment (coma, brain damage, etc.)
☐ 6 Other:

C. HEARING

☐ 1 No impairment or impairment is compensated for with use of hearing aid
☐ 2 Slight impairment; speaker's voice must be raised slightly even if client uses a hearing aid
☐ 3 Substantial hearing loss; speech must be very loud even if client uses a hearing aid
☐ 4 Unable to hear
☐ 5 Cannot verify because of severe impairment (coma, brain damage, etc.)
☐ 6 Other:

12. NUTRITION

Height: Weight:

Weight/appetite/nutrition/eating disorder comments:

13. SPECIAL DIET

☐ 1 Yes ☐ 2 No

If yes, describe diet, including supplemental nourishments, reason for diet, and compliance (if known):

14. SKIN PROBLEMS WITHIN LAST 14 DAYS

☐ 1 Yes ☐ 2 No

If yes, describe type of problems (skin tears, rash, bruises, wound, etc.), severity and location:

☐ At risk of skin breakdown due to:
☐ Quadriplegia ☐ Wheelchair dependent
☐ Paraplegia ☐ Bedfast

15. TREATMENT, THERAPY, AND SELF-CARE TRAINING

☐ **Check here if none.**

A. TREATMENTS/THERAPIES (TYPE AND FREQUENCY)

COMMENTS ON POTENTIAL TREATMENT/THERAPY

B. SELF-CARE TRAINING (OPTIONAL) (THESE ARE NOT MPC PROVIDER RESPONSIBILITIES)

1. CHILD'S LAST NAME	FIRST NAME	MIDDLE INITIAL	ASSESSMENT DATE

SECTION 3. FUNCTIONAL ABILITIES AND SUPPORTS | **SERVICE PLAN**

CODING, as described in WAC 388-15: M - Minimal S - Substantial T - Total

1. **(AMBULATION)*** What special help is needed for this child to be mobile relative to age and disability?

☐ 0	No special assistance is needed.	1. Provider task:
☐ 8 (M)	Needs hand held on stairs or uneven surfaces or uses adaptive devices with minimal assistance. **(age 4 or older)**	2. Frequency/schedule:
☐ 10 (S)	Is mobile inside but needs assistance of another person outside. **(age 4 and older)**	OUTCOME: Safety ensured.
☐ 12 (T)	Only mobile with regular assistance of another person, or needs ongoing assistance with adaptive devices. No carrying or lifting of child or equipment required. **(age 4 or older)** **or** Always requires total physical assistance, i.e., needs to be carried or provided physical assistance to walk, or caregiver must push or carry manual wheelchair or other ambulation equipment. **(age 2 or older)**	☐ **No provider task required.** **Score:** _____

2. **(BATHING)*** What special help does the child need to bathe relative to chronological age expectations and due to his/her disability?

☐ 0	No unusual help is needed.	1. Provider task:
☐ 4 (M)	Minor physical and verbal assistance, such as adjusting water temperature. **(age 8 or older)** **or** Requires the presence of an adult in the room due to child health condition **(age 5 or older)**	2. Frequency/schedule:
☐ 8 (S)	Requires physical help in a large part of the bathing activity, for example, to lather, wash, and/or rinse own body or hair. **(age 5 or older)**	OUTCOME: Health and hygiene maintained. ☐ **No provider task required.** **Score:** _____
☐ 10 (T)	Child is dependent on others to provide a complete bath, i.e., continuous physical support or needs more than one adult to complete task. **(age 5 or older)**	

3. **(BODY CARE)*** What specialized body care or exercises are needed for a child **age 10 or older** due to their disability?

☐ 0	No specialized body care is needed.	1. Provider task:
☐ 4 (M)	Needs reminding or occasional physical assistance to apply non-prescription ointments or lotions; or to perform non-sterile bandage or dressing change; to perform exercises	2. Frequency/schedule:
☐ 5 (S)	Child requires limited physical help to apply ointment, lotion, or to perform non-sterile bandage care or exercise on a daily basis.	OUTCOME: Health and safety ensured. ☐ **No provider task required.** **Score:** _____
☐ 6 (T)	Child is dependent on other to perform all required body care.	

4. **(DRESSING)*** What special help does a child need with dressing, including orthotics, relative to chronological age expectations?

1. CHILD'S LAST NAME	FIRST NAME	MIDDLE INITIAL	ASSESSMENT DATE

SECTION 3. FUNCTIONAL ABILITIES AND SUPPORTS (CONTINUED) | **SERVICE PLAN**

5. **(EATING) *** What additional help is needed for this child to eat, relative to chronological age expectations?

☐ 0	No special help required.
☐ 5 (M)	Can feed self, chew, swallow but is • **4 years of age or older** and needs verbal prompting to maintain adequate intake; **or** • **10 years of age or older** and needs assistance with such things as cutting up food, buttering bread, pouring liquids.
☐ 12 (S)	A child **age three or older** who can feed self, but • Needs standby assistance for occasional gagging, choking, or swallowing difficulty, **or** • Needs assistance with such things as utensils, cups, etc., **or** • Must be fed some of the time by mouth by another person. • Must be totally fed by another person.
☐ 16 (T)	A **child of any age** who needs extraordinary time and supervision due to: • behavior issues, or • because child frequently gags or chokes due to swallowing difficulties.
☐ **0 - 12**	**Score allowed only for family member providers** who feed the child by stomach or nasal tube or venous access.

1. Provider task:

2. Frequency/schedule:

OUTCOME: Maintain nutritional status.

☐ **No provider task required.**

Score: _____

6. **(HOUSEWORK)** What impact does the child's disability have upon housework demands beyond that expected of a typical child of the same age?

☐ 0	No additional housework needs.
☐ 5 (T)	As a result of the child's disability, extraordinary housekeeping measures are required, such as daily extensive cleaning due to a child's severe allergies, or substantial clean-up is required due to destructive behaviors which are a result of the child's disability. **(child of any age)**

1. Provider task:

2. Frequency/schedule:

OUTCOME: Maintain a safe, healthy, clean environment.

☐ **No provider task required.**

Score: _____

7. **(LAUNDRY)** What is the nature of the demands upon the caregiver to do more laundry than is expected for this child?

1. CHILD'S LAST NAME	FIRST NAME	MIDDLE INITIAL	ASSESSMENT DATE

SECTION 3. FUNCTIONAL ABILITIES AND SUPPORTS (CONTINUED)

8. **(MEAL PREPARATION**) Does the child require additional time or activities to prepare simple meals due to his/her disability and relative to chronological age expectations?

☐ 0	No unusual time or activities required, or the child is able to participate as expected in simple meal preparation.	1. Provider task: 2. Frequency/schedule: OUTCOME: Ensure balanced diet and nutrition. ☐ **No provider task required.** **Score:** ____
☐ 6 (T)	Unusual time or tasks are required, such as ground food, special diet preparations. **(child of any age)** **or** A child is totally dependent on others for even simple meal preparation due to cognitive, physical, or behavioral disability. **(age 10 and older)**	

9. **(PERSONAL HYGIENE)*** What special help does the child need due to his/her disability with personal hygiene and grooming relative to chronological age expectations?

☐ 0	No additional assistance required.	1. Provider task: 2. Frequency/schedule: OUTCOME: Hygiene maintained. ☐ **No provider task required.** **Score:** ____
☐ 4 (M)	Child must be reminded and supervised at least some of the time. **(age 12 or older)**	
☐ 6 (S)	Regularly requires direct assistance with such tasks as combing hair, brushing teeth, menses care, and shaving. **(age 8 and older)**	
☐ 8 (T)	All personal hygiene must be done by someone else. **(age 5 and older)**	

10. **(POSITIONING)*** What supports are needed to move a child to and from a lying position or position their body in bed and/or chair due to his/her disability?

1. CHILD'S LAST NAME	FIRST NAME	MIDDLE INITIAL	ASSESSMENT DATE

SECTION 3. FUNCTIONAL ABILITIES AND SUPPORTS (CONTINUED) | **SERVICE PLAN**

11. **(TOILETING)*** What additional help in toileting is needed for this child due to the child's disability and relative to chronologicalage expectations?

☐ 0 No additional help is needed.

☐ 5 (M) Unusual verbal cueing is needed and/or occasional/infrequent daytime toileting accidents and/or a toileting program must be followed. **(age 4 or older)**

or

Needs occasional physical assistance for one or more of the following: clothing adjustment, washing hands, wiping, and cleansing. **(age 4 or older)**

☐ 12 (S) Cannot get to the toilet without assistance, or needs substantial physical assistance at least daily with part of the task. **(age 4 or older)**

☐ 16 (T) Requires total cleansing; unable to use toilet; or requires protective garments/diapers. **(age 4 or older)**

or

Child **of any age** has a medical condition requiring more frequent, scheduled diaper changes on a 24 hours basis.

or

Child who is incontinent and requires diaper changes at night only. **(age 8 or older)**

1. Provider task:

2. Frequency/schedule:

OUTCOME: Safety and hygiene ensured.

☐ **No provider task required.**

Score: _____

12. **(TRANSFER)*** What additional assistance with transferring is needed for this child?

☐ 0 No transferring is needed.

☐ 4 (M) Needs assistance on occasion**. (age 4 and older)**

☐ 8 (S) A child **age 4 or older** needs daily assistance, and:
- Can bear some weight and assist with their transfer **or**
- Weighs less than 30 lbs.

☐ 11 (T) A **child of any age** who weighs more than 30 lbs. and requires total physical support of the caregiver to transfer.

1. Provider task:

2. Frequency/schedule:

OUTCOME: Safety ensured.

☐ **No provider task required.**

Score: _____

13. **(TRAVEL TO MEDICAL SERVICES)** When a child of any age has a disability that requires a second adult to accompany the parent/guardian in order to transport the child to necessary medical services?

☐ 0 No unusual transportation and medical services needed.

☐ 1 (M) Child's medical condition requires a second adult less than monthly to assist with transport to medical appointments.

☐ 2 (S) A second adult is needed at least monthly to assist with transport to medical appointments.

☐ 3 (T) A second adult is needed at least weekly to assist with transport to medical appointments.

1. Provider task:

2. Frequency/schedule:

OUTCOME: Safety ensured.

☐ **No provider task required.**

Score: _____

1. CHILD'S LAST NAME	FIRST NAME	MIDDLE INITIAL	ASSESSMENT DATE

SECTION 3. FUNCTIONAL ABILITIES AND SUPPORTS (CONTINUED)	SERVICE PLAN
15. SELF-SUPERVISION (ABILITY TO BE LEFT ALONE WITHOUT RISK TO SELF)	
☐ A. No supervision hours because of any or all of the following: • No protective supervision needs that exceed chronological age expectations. • No unscheduled task hours warranted. • No additional supervision hours needed in addition to the authorized Task hours score in 14.B. • Child is in foster or group care and supervision hours require an ETP.	No supervision hours allowed for DCFS foster parents or group care providers.
☐ B. Unscheduled task hours are additional hours required for ambulation, toileting, transfer, and positioning. An item must score "total" before scoring "additional supervision." Justify additional hours in this space or under "additional comments" section of the assessment. Task: Hours per month: Justification:	1. Provider task: 2. Frequency/schedule: OUTCOME: Safety and hygiene ensured. ☐ **No provider task required.**
C. Cognitive/protective supervision are only those hours that exceed chronological age expectations for the following children: • The primary child in the household • The secondary child with ETP (and for a different IP provider). Hours per month: _____ are required for cognitive/protective supervision due to one of the following: ☐ 1 Child **age 2 or older** has behavior challenges resulting in health and safety issues for self and/or others which exceed chronological age expectations due to a disability such as, dual diagnosis based on a current mental health diagnosis or autism. Explain: **OR** ☐ 2 Child **age 11 or older** has disability which causes impaired judgment related to health and safety issues, requiring supervision beyond chronological age level expectations. Explain:	1. Provider task: NO protective supervision hours can be authorized to the foster care or group care provider of the child. 2. Frequency/schedule: OUTCOME: Safety and hygiene ensured. ☐ **No provider task required.**

1. CHILD'S LAST NAME	FIRST NAME	MIDDLE INITIAL	ASSESSMENT DATE

SECTION 3. FUNCTIONAL ABILITIES AND SUPPORTS (CONTINUED)

16A. SERVICES CHILD CURRENTLY RECEIVES

☐ Public Health Department ☐ DDD Case Management ☐ Other, specify below:
☐ Child Development Services ☐ DCFS
☐ Mental Health Services ☐ School District Services

16B. MULTIPLE PERSON HOUSEHOLDS (MPC, COPES, CHORE) **NOT APPLICABLE TO CHILDREN'S FOSTER HOME**

	NAME(S)	DIVISION(S)
PRIMARY CLIENT		
SECONDARY CLIENT(S)		

☐ Household members with agency providers (list names):

☐ Household members with individual providers (list names):

17. TOTAL MEDICAID PERSONAL CARE HOURS PER MONTH

A. MPC PROVIDER TASK HOURS PER MONTH	B. SUPERVISION HOURS PER MONTH	C. TOTAL ALLOWABLE HOURS PER MONTH	D. APPROVED ETP HOURS PER MONTH

18. Approval to exceed age limit, task hour limit, and one-on-one supervision hour limit and/or to exceed program maximum using Exception to Policy. If you need additional space to write justifications, use the following page under "Additional Comments."

☐ Approval to exceed age limit: _____ Hours _____ Hours to exceed program maximum (ETP)
Justification:

☐ Approval to exceed task hour limit: _____ Hours _____ Hours to exceed program maximum (ETP)
Justification:

☐ Approval to exceed one-on-one supervision hourly limit in DCFS Foster Care: _____ Hours _____ Hours to exceed program maximum (ETP)
Justification:

Approval for additional supervision and/or task hours and Exception to Policy Requests:

REGIONAL ADMINISTRATOR OR DESIGNEE SIGNATURE	DATE	END DATE

PROVIDER	FOSTER CARE HOME		INDIVIDUAL PROVIDER (PRIMARY)	INDIVIDUAL PROVIDER (SECONDARY)	AGENCY
	FOSTER CARE PARENT	INDIVIDUAL PROVIDER			
DDD	0	0	(1 - 96) or (1 - 144)	(1 - 96)	(1 – 112)
DCFS	(1 - 116)	(1 - 60)	(1 - 96) or (1 - 144)	(1 - 96)	See DCFS guide

I am aware of all possible alternatives available to me, and I agree with the above service plan. I authorize the Department of Social and Health Services (DSHS) and/or the Nurse Oversight Agency to obtain or release information to my provider necessary to development or provision of my service plan.

CHILD'S REPRESENTATIVE'S SIGNATURE	DATE

1. CHILD'S LAST NAME	FIRST NAME	MIDDLE INITIAL	ASSESSMENT DATE

ADDITIONAL COMMENTS

Caregivers will follow UNIVERSAL PRECAUTIONS when exposed to body fluids and wastes during client care.

The MPC program requires a registered nurse to visit the client to evaluate the provision of services, answer questions, and provide training to the MPC provider, if needed. _____ will provide NURSE OVERSIGHT visits _____ times a year. The MPC provider(s) is _____ as of (date) _____.

APPENDIX F AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

As allowed under section 1902(a)(32)(B) of the Social Security Act, payment for some services (i.e., prevocational services, supported employment, community access and person-to-person) is made to governmental agencies (counties).

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

____ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).
____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.
__X__ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.
____ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
a. When the individual was eligible for Medicaid waiver payment on the date of service;
b. When the service was included in the approved plan of care;
c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

__X__ Yes
____ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

____ All claims are processed through an approved MMIS.
__X__ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

__X__ The Medicaid agency will make payments directly to providers of waiver services.
____ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.
____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.
__X__ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):
Counties

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method
Please see attachment F-1

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

ATTACHMENT F-1

BILLING PROCESS, AUDIT TRAIL AND RECORDS RETENTION

BILLING PROCESS

Most waiver services are paid and tracked through the State's automated Social Services Payment System (SSPS). The State's A-19 invoice review and payment system is used to pay for services (e.g., prevocational services, supported employment, community access, person to person) funded through the counties and therefore not incorporated into the SSPS system, with electronic verification of client eligibility and vendor charges. The County Human Resource Information System (CHRIS) is used to track services funded through the counties.

Overview of the Social Service Payment System (SSPS)

The Social Service Payment System (SSPS) authorizes the delivery and/or purchase of services for recipients, collects required state and federal statistical and management data, and initiates the payment process for purchased services. DSHS organizational and program units use this system to authorize expenditures for social services.

Attachment F-1-a from the SSPS Manual explains the edits that prevent input errors in SSPS payment authorizations.

On the basis of service codes, SSPS expenditure information interfaces with the department's accounting system (Financial Reporting System/Agency Financial Reporting System-FASTRACK/AFRS).Division of Developmental Disabilities (DDD) Central Office staff maintain an account coding crosswalk that links waiver-covered SSPS service codes with the FASTRACK/AFRS system.

Overview of the County Human Resource Information System (CHRIS)

Billings for services (e.g., prevocational services, supported employment services, community access, person to person) contracted through the counties are submitted monthly by each county to the department. Each billing includes the program name (e.g., supported employment services, community access services), a list of clients that were in the program that month, identification of those clients on each waiver, the total units of service provided by the program, the cost per unit of service, and the amount billed the division for each client.

Charges billed to the waiver program for supported employment services exclude any wages earned by recipients. Client hours worked or spend on site are listed on billings separately from the hours of service provided the client. Department (e.g., Single State Agency) payments are only for hours of service

provided.

ATTACHMENT F-1
(CONTINUED)

BILLING PROCESS,
AUDIT TRAIL AND RECORDS RETENTION

Payment is made on A-19 invoice vouchers for all day programs and supported employment services. Information on total payments for Waiver and non-waiver clients by service type is carried forward to the A-19 by Division accounting staff.

Overview of the A-19 Invoice Voucher

The A-19 invoice voucher is a state payment form that identifies a request for reimbursement of prevocational services, supported employment, community access or person to person services. The A-19 contains and/or is accompanied by support documentation (i.e., CHRIS forms) that identifies all waivered services for waiver clients, units of service, and rates per unit of service. The A-19 invoice vouchers are manually coded and processed through the state's vendor payment system.

AUDIT TRAIL

All payments are backed by an audit trail. The trail begins prior to delivery of service to the individual recipient, and follows through to the claim for federal financial participation (FFP). Key steps in the audit trail include:

- Verification of client and provider eligibility for Medicaid;
- Service authorization;
- Verification of service delivery;
- Invoicing and payment; and
- Calculation of FFP.

Client Eligibility:Individual client case records document the recipient's eligibility for the waiver. Persons verified by the DDD case manager as meeting all eligibility requirements and placed on the waiver are identified in the Common Client Data Base (CCDB). The CCDB is a division-specific database consisting of client characteristic/status information provided and maintained by regional DDD staff. It is a computer-based system for which Division staff have data input and systems responsibility. Information on client eligibility is maintained in client case records for a minimum of five (5) years.

Provider Eligibility: All providers of waiver services must hold

current contracts/provider agreements that define the services to

ATTACHMENT F-1
(CONTINUED)

BILLING PROCESS,
AUDIT TRAIL AND RECORDS RETENTION

be provided, and the payment for those services. Contract agreements additionally require providers to document and retain records of all services and charges for at least three (3) years after service delivery, and to make such records available on request for state and federal inspection and audit.

Service Authorization: Waiver services are authorized prior to service delivery by the DDD case manager responsible for the recipient's individual written plan of care. Case managers ensure that those services authorized are included in the approved plan of care. Service authorizations specify the client; the type and amount of service to be provided; the begin and end dates for delivery of the service, the provider; the payment rate for the service; a source of funds code designating if the service is to be provided and charged under the waiver; and identification of the case manager authorizing the service.

Services paid under the automated SSPS system are authorized electronically. Records of electronic authorizations are retained for a minimum of three (3) years on microfiche. Paper authorization forms for services paid under the manual A-19 system are retained in the official client records for a minimum of five (5) years.

Service Delivery: All providers are required to retain records which document actual service delivery on an individual recipient basis. These records must be in addition to and document information contained on the billing document. The specific format and content of such records varies according to the particular service provided. Typical documentation includes records of days attended, hours of services delivered, specific service interventions used, and progress toward individual training plan objectives.

Records Maintained by Providers

Contract agreements with providers of waiver services require providers to document and retain records of all services and charges for at least three (3) years after service delivery. Typical documentation includes records of days attended, hours of services delivered, specific service interventions used, and progress toward individual training plan objectives.

Acute care and other regular state plan services are paid and tracked through the State's Medicaid Management Information System (MMIS). No waiver services are paid or tracked through

the MMIS.

ATTACHMENT F-1
(CONTINUED)

BILLING PROCESS,
AUDIT TRAIL AND RECORDS RETENTION

Service Invoicing and Payment: Completion of the electronic SSPS service authorization results in automatic issuance of an invoice to the provider for each authorized service. The invoice identifies the individuals authorized to receive the particular service. The provider includes on the invoice the type of unit (e.g., hour, day), the number of units delivered during the month to each client, signs a certification statement, and returns it to the state for processing. Upon return to the state, it is entered into an electronic database and electronically cross-checked to verify consistency with authorized service types, delivery dates, service amounts, and unit rates; after which a warrant is issued.

FFP: The FFP for waivered services is calculated through the state's approved and automated cost allocation plan. The FFP is collected through two payment systems: one automated (SSPS) and one manual (Invoice voucher A-19). Both payment systems' accounting information is processed through the State of Washington Agency Financial Reporting System (AFRS) and the Department of Social and Health Services FASTRACK System which includes the Federal Cost Allocation Plan.

RECORDS RETENTION

Records Maintained by the Medical Assistance Unit

The single state agency for Washington State's Medicaid program is the Department of Social and Health Services. The Medical Assistance Administration of the Department of Social and Health Services is the Medical Assistance Unit within the department. The Medical Assistance Administration maintains microfilm copies of provider billing documents for regular state plan services on-site for five (5) years and in archives for an additional two (2) years. Computer records of Medicaid payments for regular state plan services are maintained for ten (10) years. On-line access to computer records of Medicaid payments for regular state plan services is available for payments going back three (3) years. The MMIS extended database of paid claims goes back an additional two (2) years. The MMIS claims payment history goes back an additional five (5) years.

Records Maintained by the Division of Developmental Disabilities

Information on client eligibility is maintained in official client case records for a minimum of five (5) years. These records are maintained in DDD regional and local offices.

Copies of provider contracts are maintained for a minimum of five

ATTACHMENT F-1
(CONTINUED)

BILLING PROCESS,
AUDIT TRAIL AND RECORDS RETENTION

(5) years in DDD regional offices.

Records Maintained by the Division of Administrative Services

Records of electronic authorizations for payment are retained for a minimum of three (3) years on microfiche, and on computer tape indefinitely. Paper authorization forms for services paid under the manual A-19 system are retained in the official client records for a minimum of five (5) years. Backup documentation for CMS-64 Reports is maintained for a minimum of three (3) years.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

WAIVER YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	46,791	10,610	145,147	2,147
2	46,824	10,610	145,416	2,147
3	46,952	10,610	145,604	2,147

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	4,273
2	4,102
3	3,938

EXPLANATION OF FACTOR C:

Check one:

_____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

__X__ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

ATTACHMENT G-1-a
PROJECTION OF FACTOR C

TABLE 1. PROJECTION OF FACTOR C

Time Period	# of Clients At Beginning of Waiver Yr.	# of Clients Added During the Year***	**Projected Factor C**
Waiver Year 1	4,267*	6	**4,273**
Waiver Year 2	4,102**	---	**4,102**
Waiver Year 3	3,938**	---	**3,938**

*Based on those on the Community Alternatives Program (CAP) Waiver (#0050.90.R2) that will meet the criteria for placement on this waiver.
**Factor C for the previous year minus the number of clients leaving the waiver as contained in Table 2 below.
***From Table 2 below.

TABLE 2. PROJECTION OF INDIVIDUALS ADDED TO AND LEAVING THE WAIVER DURING THE WAIVER PERIOD

Time Period	# of Clients Moved From ICF/MRs	# of Clients Diverted	Total Clients Added*	Clients Leaving The Waiver**
Waiver Year 1	0	6	6	171
Waiver Year 2	---	---	---	164
Waiver Year 3	---	---	---	158

*Clients will only be added when funding is provided by the Legislature. The waiver will be amended as necessary to accommodate any additional waiver recipients.
**From Table 3 below.

Since the extent to which additional funding will allow for expansion of the waiver remains to be determined, no growth in the number served is assumed during the last two years of the waiver period. As additional funding becomes available, waiver amendment requests to increase the number served will be submitted.

The basis for projections of the phase-out of waiver recipients (Table 3) is the information contained in Table 4 below, which includes data for CAP Waiver recipients from 7/1/2001 through 6/30/2002 (SFY02, the fifth waiver year of the waiver renewal period). Based on experience during SFY02, an estimated 4% of individuals on this waiver will leave the waiver each year. . Since the population on this waiver tends to be older and less likely to move but more likely to require additional support, of those leaving the waiver 30% are projected to leave the waiver due to death, 20% are projected to be no longer waiver eligible (e.g., to increased earnings due to employment) 10% are projected to move into an institution, 25% are projected to move out of state, and 5% are projected to leave the waiver due to no longer wanting to be on the waiver and/or to no longer wanting Division services.

ATTACHMENT G-1-a (CONTINUED)
PROJECTION OF FACTOR C

TABLE 3. PHASE-OUT PROJECTIONS DURING THE WAIVER PERIOD*

Phase-Out Due To:	Waiver Year 1	Waiver Year 2	Waiver Year 3
Death	51	49	47
Ineligibility	34	33	32
Moved into an Institution	17	16	16
Moved out of State	43	41	39
No Longer Want DD Services and/or to be on the waiver	9	8	8
Other	17	17	16
TOTAL #	**171**	**164**	**158**
TOTAL MONTHS ON WAIVER	1,155	1,097	1,070

***Based on Table 4.**

TABLE 4. PHASE-OUT FROM THE CAP WAIVER: 7/1/2001-6/30/2002

Month	# of Deaths	No Longer Waiver-Eligible	Moved into an Institution	Moved Out of State	No longer Wants DDD Services and/or to be on the waiver	Other	TOTAL
7/2001	9	7	2	18	4	3	**43**
8/2001	12	4	1	18	2		**37**
9/2001	7	7	3	18	2	3	**40**
10/2001	7	7	3	12	2		**31**
11/2001	8	9	3	7	1	6	**34**
12/2001	8	10	2	8	4	5	**37**
1/2002	8	3	1	13	4	2	**31**
2/2002	8	6	2	5	4	6	**31**
3/2002	13	14	2	6	9	2	**46**
4/2002	10	11		7	3	5	**36**
5/2002	5	6	1	6	2	4	**24**
6/2002	6	10	2	8	3	4	**33**
TOTAL	**101**	**94**	**22**	**126**	**40**	**40**	**423**
% of Total	23.8%	22.2%	5.2%	29.8%	9.5%	9.5%	100.0%

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2
FACTOR D
LOC: __ICF/MR

Demonstration of Factor D estimates: (Attached; See also Attachment G-2-a)

Waiver Year 1_____ 2_____ 3_____ 4_____ 5

Waiver Service	#Undup.Recip. (users)	Avg. # Annual Units/User	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

GRAND TOTAL (sum of Column E):
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:

FACTOR D(Divide total by number of recipients):

AVERAGE LENGTH OF STAY:

APPENDIX G-2
FACTOR D
LOC: __ICF/MR

Demonstration of Factor D estimates:

Third Waiver
Renewal Year 1__X__ 2_____ 3 _____

Waiver Service/Unit	# Undup. Recip. (Users)	Avg. # Annual Units/User	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1. Personal Care Services(Hr)	786	928.7	$ 10.14	$ 7,401,776
2. Respite Care (Hour)	470	854.3	10.77	4,324,381
3. Habilitation Services				
a. Residential Habilitation				
Contracted Supported Living (Day)	2,680	356.4	132.52	126,576,743
State-Staffed Supported Living (Day)	98	355.2	273.40	9,516,945
Group Home (Day)	470	342.2	97.53	15,686,140
Child Placing Agency (Month)	22	8.3	3,712.25	677,857
Family Foster Care (Month)	290	10.6	2,167.55	6,663,049
Staffed Residential Home (Day)	49	237.2	216.96	2,521,683
Foster Group Care (Month)	49	8.3	5,324.62	2,165,523
Alternative Living (Hr)	342	252.5	14.03	1,211,561
Attendant Care (Hour)	241	1,620.1	8.99	3,510,092
b. Prevocational Services (Month)	686	10.6	518.65	3,771,415
c. Supported Employment Services (Month)	1,124	10.6	500.74	5,966,017
4. Environmental Accessib. Adaptations (Each)	43	1.0	1,000.00	43,000
5. Skilled Nursing (Hour)	1,026	60.2	25.52	1,576,248
6. Transportation (Mile)	598	2,078.0	0.31	385,220

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Third Waiver
Renewal Year 1 X 2 3

Waiver Service/Unit	# Undup. Recip. (Users)	Avg. # Annual Units/User	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
7. Specialized Medical Equipment and Supplies (Each)	17	2.4	310.68	12,676
8. Adult Foster Care (Day)	137	218.3	46.93	1,403,540
9. Adult Residential Care (Day)	21	208.9	23.89	104,803
10. Physical Therapy Services (Hour)	132	36.6	40.39	195,132
11. Occupational Therapy Services (Hour)	85	16.5	47.22	66,226
12. Speech,Hearing, and Language Services (Hour)	43	31.9	28.51	39,107
13. Behavior Management and Consultation (Hour)	430	28.3	54.84	667,348
14. Staff/Family Consultation and Training (Hour)	30	263.1	15.85	125,104
15. Specialized Psychiatric Services (Each)	43	5.9	143.06	36,294
16. Community Access (Month)	910	10.6	473.45	4,566,899
17. Community Guide (Each)	4	2.4	64.71	621
18. Person to Person (Month)	179	8.3	485.25	720,936

GRAND TOTAL (sum of column E): $ 199,936,336

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS: 4,273

FACTOR D (Divide total by number of recipients): $46,791

AVERAGE LENGTH OF STAY: 358.3 days

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Third Waiver
Renewal Year 1_____ 2__X___ 3_____

Waiver Service/Unit	# Undup. Recip. (Users)	Avg. # Annual Units/User	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1. Personal Care Services(Hr)	762	928.7	$ 10.14	$ 7,175,768
2. Respite Care (Hour)	451	854.3	10.77	4,149,566
3. Habilitation Services				
a. Residential Habilitation				
Contracted Supported Living (Day)	2,589	356.4	132.52	122,278,801
State-Staffed Supported Living (Day)	94	355.2	273.40	9,128,498
Group Home (Day)	451	342.2	97.53	15,052,019
Child Placing Agency (Month)	20	8.3	3,712.25	616,234
Family Foster Care (Month)	258	10.6	2,167.55	5,927,816
Staffed Residential Home (Day)	45	237.2	216.96	2,315,831
Foster Group Care (Month)	43	8.3	5,324.62	1,900,357
Alternative Living (Hr)	328	252.5	14.03	1,161,965
Attendant Care (Hour)	235	1,620.1	8.99	3,422,704
b. Prevocational Svcs (Month)	658	10.6	518.65	3,617,480
c. Supported Employment Services (Month)	1,079	10.6	500.74	5,727,164
4. Environmental Accessib. Adaptations (Each)	41	1.0	1,000.00	41,000
5. Skilled Nursing (Hour)	984	60.2	25.52	1,511,723
6. Transportation (Mile)	574	2,078.0	0.31	369,759

State: Washington 3 Date: 1/1/2004

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Third Waiver
Renewal Year 1_____ 2__X___ 3 _____

Waiver Service/Unit	# Undup. Recip. (Users)	Avg. # Annual Units/User	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
7. Specialized Medical Equipment and Supplies (Each)	16	2.4	310.68	11,930
8. Adult Foster Care (Day)	136	218.3	46.93	1,393,295
9. Adult Residential Care (Day)	21	208.9	23.89	104,803
10. Physical Therapy Services (Hour)	127	36.6	40.39	187,741
11. Occupational Therapy Services (Hr)	82	16.5	47.22	63,889
12. Speech,Hearing, and Language Services (Hour)	41	31.9	28.51	37,288
13. Behavior Management and Consultation (Hour)	413	28.3	54.84	640,964
14. Staff/Family Consultation and Training (Hour)	29	263.1	15.85	120,934
15. Specialized Psychiatric Services (Each)	41	5.9	143.06	34,606
16. Community Access (Month)	874	10.6	473.45	4,386,230
17. Community Guide (Each)	4	2.4	64.71	621
18. Person to Person (Month)	172	8.3	485.25	692,743

GRAND TOTAL (sum of column E): $ 192,071,729

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS: 4,102

FACTOR D (Divide total by number of recipients): $46,824

AVERAGE LENGTH OF STAY: 358.6 days

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Third Waiver
Renewal Year 1_____ 2_____ 3__X___

Waiver Service/Unit	# Undup. Recip. (Users)	Avg. # Annual Units/User	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1. Personal Care Services(Hr)	743	928.7	$ 10.14	6,996,844
2. Respite Care (Hour)	433	854.3	10.77	3,983,951
3. Habilitation Services				
a. Residential Habilitation				
Contracted Supported Living (Day)	2,509	356.4	132.52	118,500,391
State-Staffed Supported Living (Day)	91	355.2	273.40	8,837,163
Group Home (Day)	433	342.2	97.53	14,451,274
Child Placing Agency (Month)	18	8.3	3,712.25	554,610
Family Foster Care (Month)	222	10.6	2,167.55	5,100,679
Staffed Residential Home (Day)	42	237.2	216.96	2,161,442
Foster Group Care (Month)	36	8.3	5,324.62	1,590,996
Alternative Living (Hr)	315	252.5	14.03	1,115,911
Attendant Care (Hour)	230	1,620.1	8.99	3,349,881
b. Prevocational Svcs (Month)	632	10.6	518.65	3,474,540
c. Supported Employment Services (Month)	1,036	10.6	500.74	5,498,926
4. Environmental Accessib. Adaptations (Each)	39	1.0	1,000.00	39,000
5. Skilled Nursing (Hour)	945	60.2	25.52	1,451,807
6. Transportation (Mile)	551	2,078.0	0.31	354,943

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Third Waiver
Renewal Year 1_____ 2_____ 3 ___X___

Waiver Service/Unit	# Undup. Recip. (Users)	Avg. # Annual Units/User	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
7. Specialized Medical Equipment and Supplies (Each)	16	2.4	310.68	11,930
8. Adult Foster Care (Day)	137	218.3	46.93	1,403,540
9. Adult Residential Care (Day)	20	208.9	23.89	99,812
10. Physical Therapy Services (Hour)	122	36.6	40.39	180,349
11. Occupational Therapy Services (Hour)	79	16.5	47.22	61,551
12. Speech,Hearing, and Language Services (Hour)	39	31.9	28.51	35,469
13. Behavior Management and Consultation (Hour)	397	28.3	54.84	616,133
14. Staff/Family Consultation and Training (Hour)	28	263.1	15.85	116,764
15. Specialized Psychiatric Services (Each)	39	5.9	143.06	32,918
16. Community Access (Month)	839	10.6	473.45	4,210,580
17. Community Guide (Each)	4	2.4	64.71	621
18. Person to Person (Month)	165	8.3	485.25	664,550

GRAND TOTAL (sum of column E): $ 184,896,575

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS: 3,938

FACTOR D (Divide total by number of recipients): $46,952

AVERAGE LENGTH OF STAY: 358.7 days

ATTACHMENT G-2-a
DERIVATION/PROJECTION OF FACTOR D

Utilization and expenditures are based upon actual utilization and expenditures for this group of clients during FY02 (7/1/01-6/30/02) projected through the course of the waiver period, with the exceptions identified below.

Utilization and expenditures for environmental accessibility adaptations are **not** based on service utilization during FY02. Projections of the use of environmental modifications are based on program staff estimates, as historical data are not readily available.

Utilization

The total number using each service is based on the percent of this group on the waiver at any time during FY02 that used the service, with the exception noted above. In addition, utilization of residential habilitation, personal care, and adult foster care services has been adjusted to reflect the aging out of individuals receiving support services from child placing agencies, family foster care, staffed residential homes, and foster group care. These providers serve individuals in the Voluntary Placement Program (VPP).* At age 21 individuals age out of the VPP and receive support services from other providers (e.g., supported living, group home, personal care). Also, the use of residential habilitation, prevocational services, supported employment services, and behavior management and consultation services has been adjusted to reflect their use by new waiver recipients.

The number of units used is based on the average number of service units used per each month on the waiver during FY02 for this group applied to the total months on the waiver projected for each waiver year, with the exception noted above.

Expenditures

Projected expenditure per unit of service is based on actual expenditures per unit of service during FY02 (with the exceptions noted above), trended forward by 1.5% to reflect the vendor rate increase provided on 7/1/2002. The trend factor does not apply (and was not applied) to the service costs for environmental accessibility adaptations, family foster care (residential habilitation), state-staffed supported living (residential habilitation) and transportation (i.e., mileage reimbursement). Other increases in expenditures from the base year are increases of 8.03% in the cost of personal care services, 8.08% in the cost of respite care services, 5.4% in the cost of adult foster care services, and 6.18% in the cost of adult residential care services, all of which reflect the impact on providers serving individuals on this waiver of targeted vendor rate increases provided by the Legislature effective October 1, 2003.

*The VPP is a foster care program for children or youth that are in a voluntary placement outside the family home. Participation in the VPP is due solely to the individual's disability (i.e., abuse and/or neglect is not at issue). Parents retain custody of their child while the child receives support services in a placement in a licensed setting.

ATTACHMENT G-2-a (CONTINUED)
DERIVATION/PROJECTION OF FACTOR D

TABLE 1. PROJECTIONS OF THE TOTAL NUMBER OF CLIENTS USING WAIVER SERVICES BY WAIVER YEAR*

Waiver Service	Waiver Year 1	Waiver Year 2	Waiver Year 3
1. Personal Care Services	786	762	743
2. Respite Care	470	451	433
3. Habilitation Services			
a. Residential Habilitation			
Privately-Contracted Supported Living	2,680	2,589	2,509
State-Staffed Supported Living	98	94	91
Group Home	470	451	433
Child Placing Agency	22	20	18
Family Foster Home	290	258	222
Staffed Residential Home	49	45	42
Foster Group Care Home	49	43	36
Alternative Living	342	328	315
Attendant Care	241	235	230
b. Prevocational Svcs	686	658	632
c. Supported Employment Svs.	1,124	1,079	1,036
4. Environmental Accessibility Adaptations	43	41	39
5. Skilled Nursing	1,026	984	945
6. Transportation	598	574	551
7. Specialized Medical Equipment and Supplies	17	16	16
8. Adult Foster Care	137	136	137
9. Adult Residential Care	21	21	20
10. Physical Therapy	132	127	122
11. Occupational Therapy	85	82	79
12. Speech,Hearing, and Language Services	43	41	39
13. Behavior Management and Consultation	430	413	397
14. Staff/Family Consultation and Training	30	29	28
15. Specialized Psychiatric Svcs	43	41	39
16. Community Access	910	874	839
17. Community Guide	4	4	4
18. Person to Person	179	172	165

*Based on the information in Table 4 below.

ATTACHMENT G-2-a (CONTINUED)
DERIVATION/PROJECTION OF FACTOR D

TABLE 2. PROJECTIONS OF THE AVERAGE ANNUAL NUMBER OF UNITS OF SERVICE PER USER EACH WAIVER YEAR*

Waiver Service	**Average Annual Number of Units of Service Per User Each Waiver Year**
1. Personal Care Services (Hour)	928.7
2. Respite Care (Hour)	854.3
3. Habilitation Services	
a. Residential Habilitation	
Privately-Contracted Supported Living (Day)	356.4
State-Staffed Supported Living (Day)	355.2
Group Home (Day)	342.2
Child Placing Agency (Month)	8.3
Foster Family Home (Day)	10.6
Staffed Residential Home (Day)	237.2
Foster Group Care Home (Day)	8.3
Alternative Living (Hour)	252.5
Attendant Care (Hour)	1,620.1
b. Prevocational Svcs (Month)	10.6
c. Supported Employment Services (Month)	10.6
4. Environmental Accessibility Adaptations (Each)	1.0**
5. Skilled Nursing (Hour)	60.2
6. Transportation (Mile)	2,078.0
7. Specialized Medical Equipment and Supplies (Each)	2.4
8. Adult Foster Care (Day)	218.3
9. Adult Residential Care (Day)	208.9
10.Physical Therapy (Hour)	36.6
11.Occupational Therapy (Hour)	16.5
12.Speech,Hearing, and Language Svcs (Hr)	31.9
13.Behavior Management and Consultation (Hour)	28.3
14.Staff/Family Consultation and Training (Hour)	263.1
15.Specialized Psychiatric Services (Each)	5.9
16.Community Access (Month)	10.6
17.Community Guide (Each)	2.4
18.Person to Person (Month)	8.3

*Based on the information in Table 6 below and an average length of stay on the waiver of 11.8 months for each waiver year.
**One per user, based on staff estimate.

ATTACHMENT G-2-a (CONTINUED)
DERIVATION/PROJECTION OF FACTOR D

TABLE 3. PROJECTIONS OF THE AVERAGE UNIT COST OF SERVICE BY WAIVER YEAR

Waiver Service	Waiver Year 1	Waiver Year 2	Waiver Year 3
1.Personal Care Services (Hour)	$ 10.14*	$ 10.14	$ 10.14
2.Respite Care (Hour)	10.77**	10.77	10.77
3.Habilitation Services			
a.Residential Habilitation			
Privately-Contracted Supported Living (Day)	132.52***	132.52	132.52
State-Staffed Supported Living (Day)	273.40	273.40	273.40
Group Home (Day)	97.53***	97.53	97.53
Child Placing Agency (Month)	3,712.25***	3,712.25	3,712.25
Family Foster Home (Day)	2,167.55	2,167.55	2,167.55
Staffed Residential Home (Day)	216.96***	216.96	216.96
Foster Group Care Home (Day)	5,324.62***	5,324.62	5,324.62
Alternative Living (Hour)	14.03***	14.03	14.03
Attendant Care (Hour)	8.99***	8.99	8.99
b.Prevocational Svcs (Month)	518.65***	518.65	518.65
c.Supported Employment Svcs ((Month)	500.74***	500.74	500.74
4.Environmental Accessibility Adaptations (Each)	1,000.00	1,000.00	1,000.00
5.Skilled Nursing (Hour)	25.52***	25.52	25.52
6.Transportation (Mile)	0.31	0.31	0.31
7.Special. Medical Equip.& Supplies(Each)	310.68***	310.68	310.68
8.Adult Foster Care (Day)	46.93****	46.93	46.93
9.Adult Residential Care (Day)	23.89*****	23.89	23.89
10.Physical Therapy (Hour)	40.39***	40.39	40.39
11. Occupational Therapy (Hour)	47.22***	47.22	47.22
12.Speech,Hearing, and Language Svcs (Hr)	28.51***	28.51	28.51
13.Behavior Management and Consult. (Hr)	54.84***	54.84	54.84
14.Staff/Family Consult. & Training (Hr)	15.85***	15.85	15.85
15.Specialized Psychiatric Svcs (Each)	143.06***	143.06	143.06
16.Community Access (Month)	473.45***	473.45	473.45
17.Community Guide (Each)	64.71***	64.71	64.71
18.Person to Person (Month)	485.25***	485.25	485.25

*Based on the costs identified in Table 7 below, increased by 1.5% (per a vendor rate increase (VRI) on 7/1/02) plus an additional 8.62% to reflect a targeted VRI to be provided on 10/1/03.
**Based on the costs identified in Table 7 below, increased by 1.5% (per a VRI on 7/1/02 plus an additional 4.88% to reflect a targeted VRI to be provided on 10/1/03.
***Based on the costs identified in Table 7 below, increased by 1.5% to reflect a VRI provided on 7/1/2002.
****Based on the costs identified in Table 7 below, increased by 1.5% (7/1/02 VRI) plus an additional 5.4% to reflect a targeted VRI to be provided on 10/1/03.
*****Based on the costs identified in Table 7 below, increased by 1.5% (7/1/03 VRI), plus an additional 6.18% to reflect a targeted VRI to be provided on 10/1/03.
Due to the state's current fiscal situation, it is anticipated no vendor rate increases will be provided during waiver years 2 and 3.

ATTACHMENT G-2-a (CONTINUED)

DERIVATION/PROJECTION OF FACTOR D

TABLE 4. PROJECTIONS OF THE NUMBER OF CLIENTS USING WAIVER SERVICES DURING WAIVER YEAR 1*

Waiver Service	% of Clients Projected to Use Each Service	Clients to Receive Svc. During Waiver Year 1
1. Personal Care Services	18%	786**
2. Respite Care	11%	470
3. Habilitation Services		
a. Residential Habilitation		
Contracted Supported Living***	62%	2,680**
State-Staffed Supported Living	2.3%	98
Group Home	11%	470
Child Placing Agency	0.6%	22****
Family Foster Home	7.4%	290****
Staffed Residential Home	1.2%	49****
Foster Group Care Home	1.2%	49****
Alternative Living	8.0%	342
Attendant Care	5.5%	241**
b. Prevocational Svcs***	16%	686
c. Supported Employment Services***	26.2%	1,124
4. Environmental Accessibility Adaptations	1%	43
5. Skilled Nursing	24%	1,026
6. Transportation	14%	598
7. Specialized Medical Equipment and Supplies	0.4%	17
8. Adult Foster Care	3%	137**
9. Adult Residential Care	0.5%	21
10.Physical Therapy	3.1%	132
11.Occupational Therapy	2.0%	85
12.Speech,Hearing, and Language Services	1.0%	43
13.Behavior Management and Consultation***	10.0%	430
14.Staff/Family Consultation and Training	0.7%	30
15.Specialized Psychiatric Services	1.0%	43
16.Community Access	21.3%	910
17.Community Guide	0.1%	4
18.Person to Person	4.2%	179

*Derived from the information in Tables 5, 6 and 7 below.
**Adjusted to reflect movement to services as indicated in Table 6 below (e.g., .18 X 4,273 = 769 + 11 + 6 = 786).
***Number served adjusted to reflect service use by new waiver clients.
****Adjusted to reflect movement from services as indicated in Table 5 below. The number served for the following year is adjusted downward per Table 5.

ATTACHMENT G-2-a (CONTINUED)

DERIVATION/PROJECTION OF FACTOR D

TABLE 5. NUMBER OF INDIVIDUALS AGING OUT OF THE VPP THAT USE VARIOUS SUPPORT SERVICES BY MONTH OF AGE-OUT*

Month Aging out of the VPP	**Support Prior to Aging Out of the VPP Provided By:** Family Foster Care	Foster Group Care	Child Placing Agency	Staffed Residential Home
Subsequent to Base Year (SYF02) & Prior to Wvr Yr 1	26	2	4	2
Waiver Yr 1-Month 1	2	1	1	1
Waiver Yr 1-Month 2	2			
Waiver Yr 1-Month 3	1	1		
Waiver Yr 1-Month 4	1			
Waiver Yr 1-Month 5	1			
Waiver Yr 1-Month 6	2			
Waiver Yr 1-Month 7	3	1		
Waiver Yr 1-Month 8	3			
Waiver Yr 1-Month 9	3			1
Waiver Yr 1-Month 10	1	1		
Waiver Yr 1-Month 11	1			
Waiver Yr 1-Month 12				
Waiver Yr 2-Month 1	3	1		
Waiver Yr 2-Month 2	1			
Waiver Yr 2-Month 3	4	1	1	
Waiver Yr 2-Month 4	1	1		
Waiver Yr 2-Month 5	1			1
Waiver Yr 2-Month 6	3	1		
Waiver Yr 2-Month 7	1			
Waiver Yr 2-Month 8				
Waiver Yr 2-Month 9	4			
Waiver Yr 2-Month 10				
Waiver Yr 2-Month 11	2			
Waiver Yr 2-Month 12	3	1		
Waiver Yr 3-Month 1	3	1		
Waiver Yr 3-Month 2	2	1		1
Waiver Yr 3-Month 3	4	1	1	
Waiver Yr 3-Month 4	4	1		
Waiver Yr 3-Month 5	2			1
Waiver Yr 3-Month 6	2			
Waiver Yr 3-Month 7	2			
Waiver Yr 3-Month 8	4	1		
Waiver Yr 3-Month 9	2		1	
Waiver Yr 3-Month 10				
Waiver Yr 3-Month 11	5	1		
Waiver Yr 3-Month 12	2	1		

*Reflects current or historical (for those already aged out) use of services under the VPP.

ATTACHMENT G-2-a (CONTINUED)
DERIVATION/PROJECTION OF FACTOR D

TABLE 6. NUMBER OF INDIVIDUALS AGING OUT OF THE VPP THAT WILL USE VARIOUS SUPPORT SERVICES BY MONTH OF AGE-OUT*

Month Aging out of the VPP	**Support After Aging Out of the VPP Provided By:**			
	Personal Care	**Supported Living**	Adult Foster Care	**Attendant Care**
Subsequent to Base Year (SYF02) & Prior to Wvr Yr 1	11	12	5	3
Waiver Yr 1-Month 1	1	2	1	
Waiver Yr 1-Month 2	1	1		
Waiver Yr 1-Month 3			1	1
Waiver Yr 1-Month 4		1		
Waiver Yr 1-Month 5				
Waiver Yr 1-Month 6		1		1
Waiver Yr 1-Month 7	1	2	1	
Waiver Yr 1-Month 8	1	2		
Waiver Yr 1-Month 9		2	1	1
Waiver Yr 1-Month 10	1	2		
Waiver Yr 1-Month 11	1			
Waiver Yr 1-Month 12				
Waiver Yr 2-Month 1	1	2	1	
Waiver Yr 2-Month 2	1			
Waiver Yr 2-Month 3	1	3	2	
Waiver Yr 2-Month 4		1		1
Waiver Yr 2-Month 5	1	1		
Waiver Yr 2-Month 6	1	2		
Waiver Yr 2-Month 7		1		
Waiver Yr 2-Month 8				
Waiver Yr 2-Month 9	1	2		1
Waiver Yr 2-Month 10				
Waiver Yr 2-Month 11		1	1	
Waiver Yr 2-Month 12	1	2		1
Waiver Yr 3-Month 1		2	1	1
Waiver Yr 3-Month 2	1	2		1
Waiver Yr 3-Month 3	1	3	1	
Waiver Yr 3-Month 4	1	2	1	1
Waiver Yr 3-Month 5	1	1		1
Waiver Yr 3-Month 6		1	1	
Waiver Yr 3-Month 7	1	1		
Waiver Yr 3-Month 8	1	2	1	
Waiver Yr 3-Month 9	1	2		
Waiver Yr 3-Month 10				
Waiver Yr 3-Month 11	2	3	1	
Waiver Yr 3-Month 12	1	2		

*Reflects projected or historical (for those already aged out) use of services after leaving the VPP. Projections based on % of VPP-Wvr age-outs using each service since inception of the VPP (1998).

ATTACHMENT G-2-a (CONTINUED)
DERIVATION/PROJECTION OF FACTOR D

TABLE 7. PERCENTAGE USING WAIVER SERVICES DURING FY02

Waiver Service	**Percentage Using Waiver Services During FY02 (7/1/01 - 6/30/02**
1. Personal Care Services	17.7%
2. Respite Care	10.8%
3. Habilitation Services	
a. Residential Habilitation	
Contracted Supported Living	61.9%
State-Staffed Supported Living	2.3%
Group Home	10.8%
Child Placing Agency	0.6%
Family Foster Care	7.4%
Staffed Residential Home	1.2%
Foster Group Care	1.2%
Alternative Living	8.0%
Attendant Care	5.5%
b. Prevocational Svcs	16.0%
c. Supported Employment Services	26.2%
4. Environmental Accessibility Adaptations	1.0%*
5. Skilled Nursing	24.0%
6. Transportation	13.6%
7. Specialized Medical Equipment and Supplies	0.4%
8. Adult Foster Care	3.0%
9. Adult Residential Care	0.5%
10.Physical Therapy	3.1%
11.Occupational Therapy	1.9%
12.Speech,Hearing, and Language Services	1.0%
13.Behavior Management and Consultation	9.9%
14.Staff/Family Consultation and Training	0.7%
15.Specialized Psychiatric Svcs	1.0%
16.Community Access	21.3%
17.Community Guide	0.1%
18.Person to Person	4.2%

***Based on staff estimate.**

ATTACHMENT G-2-a (CONTINUED)
DERIVATION/PROJECTION OF FACTOR D

TABLE 8. UNITS OF WAIVER SERVICES USED BY WAIVER CLIENTS DURING FY02 (7/1/2001 – 6/30/2002)

Waiver Service	**# of Units of Service Received During Each Month on the Waiver**
1. Personal Care Services (Hour)	78.7
2. Respite Care (Hour)	72.4
3. Habilitation Services	
a. Residential Habilitation	
Contracted Supported Living (Day)	30.2
State-Staffed Supported Living (Day)	30.1
Group Home (Day)	29.0
Child Placing Agency (Month)	0.7
Family Foster Care (Day)	0.9
Staffed Residential Home (Day)	20.1
Foster Group Care (Day)	0.7
Alternative Living (Hour)	21.4
Attendant Care (Hour)	137.3
b. Prevocational Services (Month)	0.9
c. Supported Employment Services (Month)	0.9
4. Environmental Accessibility Adaptations(Each)	*
5. Skilled Nursing (Hour)	5.1
6. Transportation (Mile)	176.1
7. Specialized Medical Equipment and Supplies (Each)	0.2
8. Adult Foster Care (Day)	18.5
9. Adult Residential Care (Day)	17.7
10.Physical Therapy (Hour)	3.1
11.Occupational Therapy (Hour)	1.4
12.Speech,Hearing, and Language Services (Hour)	2.7
13.Behavior Management and Consultation (Hour)	2.4
14.Staff/Family Consultation and Training (Hour)	22.3
15.Specialized Psychiatric Services (Each)	0.5
16.Community Access (Month)	0.9
17.Community Guide (Each)	0.2
18.Person to Person (Month)	0.7

***One per user, based on staff estimate.**

ATTACHMENT G-2-a (CONTINUED)

DERIVATION/PROJECTION OF FACTOR D

TABLE 9. COST PER UNIT OF WAIVER SERVICES FOR WAIVER CLIENTS DURING FY02 (7/1/2001 - 6/30/2002)

Waiver Service	**Average Cost per Unit of Waiver Service Received During FY02**
1. Personal Care Services (Hour)	$9.20
2. Respite Care (Hour)	10.12
3. Habilitation Services	
a. Residential Habilitation	
Contracted Supported Living (Day)	130.56
State-Staffed Supported Living (Day)	273.40
Group Home (Day)	96.09
Child Placing Agency (Month)	3,657.39
Family Foster Care (Month)	2,167.55
Staffed Residential Home (Day)	213.75
Foster Group Care (Month)	5,245.93
Alternative Living (Hour)	13.82
Attendant Care (Hour)	8.86
b. Prevocational Svcs (Month)	510.99
c. Supported Employment Services (Month)	493.34
4. Environmental Accessibility Adaptations(Each)	1,000.00*
5. Skilled Nursing (Hour)	25.14
6. Transportation (Mile)	0.31
7. Specialized Medical Equipment and Supplies (Each)	306.09
8. Adult Foster Care (Day)	43.87
9. Adult Residential Care (Day)	22.17
10.Physical Therapy (Hour)	39.79
11.Occupational Therapy (Hour)	46.52
12.Speech,Hearing, and Language Services (Hour)	28.09
13.Behavior Management and Consultation (Hour)	54.03
14.Staff/Family Consultation and Training (Hour)	15.62
15.Specialized Psychiatric Services (Each)	140.95
16.Community Access (Month)	466.45
17.Community Guide (Each)	63.75
18.Person to Person (Month)	478.08

***Based on staff estimate.**

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Residential Habilitation may be provided in a family foster home, foster group care facility, group home, group training home, or staffed residential home.
Adult foster care services are provided in adult family homes.
Adult residential care services are provided in licensed boarding homes.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Residential habilitation services may be provided in a family foster home.

Below is an explanation of the method used by the State to exclude Medicaid payment for room and board.

ATTACHMENT G-3-a

DOCUMENTATION OF APPROPRIATE CLAIMING
FOR HOME SUPPORTS

Adult Family Home

Payment for the room and board for an adult family home resident is made under a stand-alone payment code. The payment made by the state is net of client payments (e.g., from SSI or other unearned or earned income). State payments for room and board are account-coded to all state dollars (i.e., are not account-coded against the division's home and community-based services waiver).

Adult Residential Care

Payment for the room and board for an adult residential care resident is made under a stand-alone SSPS code. The payment made by the state is net of client payments (e.g., from SSI or other unearned or earned income). State payments for room and board are account-coded to all state dollars (i.e., are not account-coded against the division's home and community-based services waiver).

Foster Family Home

Payment for the room and board for a foster family home resident is made under a stand-alone payment code. The payment made by the state is net of any payment made on behalf of the child (i.e., using SSI) and is account-coded to all state dollars (i.e., is not account-coded against the division's home and community-based services waiver).

Foster Group Care Facility

Payment for the room and board for a foster group care facility resident is made under a stand-alone payment code. The payment made by the state is net of any payment made on behalf of the child (i.e., using SSI) and is account-coded to all state dollars (i.e., is not account-coded against the division's home and community-based services waiver).

Group Home/Group Training Home

The state of Washington's claim for residential habilitation services provided in group homes and group training homes is based on the cost of group home services only (i.e., not based on the total cost of the group home, which includes room and board). The individual pays for the cost of room and board using earned or unearned income. If the individual’s contribution is less that the full cost of the room and board, the payment toward the cost of room and board made by the state is account-coded to all state dollars to ensure that no federal funding is claimed. The rate for room and board for most group homes has been standardized at $492.50 per month. A few (i.e., the larger) group homes have room and board rates less than $492.50.

ATTACHMENT G-3-a

DOCUMENTATION OF APPROPRIATE CLAIMING
FOR HOME SUPPORTS
(Continued)

Individuals Residing in Their Own Residence

Waiver clients who live in their own home (e.g., house, apartment) pay for their room and board out of their own resources (e.g., SSA, SSI, earnings from supported employment). Since supportive living services (either state-staffed or privately contracted) do not include room and board, payments for those services (which are claimed under Title XIX) do not include the cost of room and board.

Staffed Residential Home

The payment for room and board for a staffed residential home resident is made under a stand-alone payment code. The payment made by the state is net of any payments made on behalf of the child (i.e., using SSI) and is account-coded to all state dollars (i.e., is not account-coded against the division's home and community-based services waiver).

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

__X__ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

_____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

_____ Based on HCFA Form 2082 (relevant pages attached).

__X__ Based on HCFA Form 372 for Waiver # 0050.90.R2 which served this population (see Attachment G-5-a).

_____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_____ Other (specify):

ATTACHMENT G-5-a

PROJECTION OF D'

TABLE 1. PROJECTION OF FACTOR D' VALUES

Waiver Time Period	Factor D'
Base Year: 7/1/2001-60/30/2002	**10,453**
Waiver Year 1	**10,610***
Waiver Year 2	**10,610**
Waiver Year 3	**10,610**

*10,610 = (10,453 X 1.015)

Factor D' values represent the Factor D' value from the 372 Report for Waiver #0050.90.R2 (the individuals that will be on this waiver are a subset of those served by Waiver #0050.90.R2) for the fifth year (7/1/01 - 6/30/02) of the waiver renewal period. A single trend factor of 1.5% has been applied to reflect a 7/1/02 vendor rate increase. No other trend factors have been applied, because it is anticipated no vendor rate increases will be provided during the course of the waiver period.

APPENDIX G-6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

_____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

_____ Based on trends shown by HCFA Form 372 for this waiver (which is being renewed), which reflect costs for an institutionalized population at this LOC. _____ provides an explanation of these projections.

_____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

_____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

__X__ Other (specify): Based on the actual per person per day average cost for ICF/MR services in the State of Washington for SFY02 (7/1/2001-6/30/2002) times the average number of days individuals will be on this waiver. See Attachment G-6-a.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

ATTACHMENT G-6-a

PROJECTIONS OF FACTOR G

TABLE 1. PROJECTIONS OF FACTOR G VALUES

Time Period	Average Daily Cost of ICF/MR Care	Average # of Days in an ICF/MR for Waiver Clients in the Absence of the Waiver*	**Projected Factor G Values**
7/1/2001–6/30/2002	404.70		
Waiver Year 1	405.10**	358.3	**145,147**
Waiver Year 2	405.51**	358.6	**145,416**
Waiver Year 3	405.92**	358.7	**145,604**

*From Appendix G-2.
**Increased by 0.1% each year to reflect a vendor rate increase of 1.92% for facilities providing 6.6% of ICF/MR services (.001 = .0192 X .066).

Values for Factor G are based upon actual per day costs for ICF/MR care in the state of Washington during SFY02 (7/1/2001 - 6/30/2002) times the number of days clients on the waiver would be in an ICF/MR if the waiver did not exist. In the absence of the waiver, waiver clients would be in an ICF/MR for the same number of days that they were on the waiver. Average number of days on the waiver is contained in the projections of Factor D (Appendix G-2).

Since 6.6% of ICF/MR bed days are provided by private contractors which received a 1.92% vendor rate increase on 7/1/2002, the FY02 average cost has been increased by 0.1% (i.e., .0192 X .066) each year. The remainder of ICF/MR bed days (i.e., 93.4%) are provided by state-run institutions. It is anticipated no state employee pay raises will be provided during the waiver period.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

_____ Based on HCFA Form 2082 (relevant pages attached).

_____ Based on HCFA Form 372 for this waiver.

_____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

___X___ Other (specify): Based on the actual cost for ICF/MR residents for SFY01 (7/1/00 - 6/30/01) trended forward based on the and vendor rate increases provided on 7/1/2001 and 7/1/2002. See Attachment G-7-a.

ATTACHMENT G-7-a

PROJECTIONS OF FACTOR G'

TABLE 1. PROJECTED FACTOR G' VALUES

Time Period	Factor G'
Base Year: 7/1/2000 – 6/30/2001	**$2,072**
Trend Factor (1.021 X 1.015)	**X 1.036**
Waiver Year 1	**2,147**
Waiver Year 2	**2,147**
Waiver Year 3	**2,147**

Projected Factor G' values are based on actual Medicaid State Plan costs for ICF/MR residents during SFY01 (7/1/00 - 6/30/01) trended forward based on vendor rate increases provided on 7/1/2001 (2.1%) and 7/1/2002 (1.5%). No additional trend factors have been applied because it is anticipated that no vendor rate increases will be provided during the waiver period. (SFY01 data were used because Medicaid vendors have up to one year to bill the MMIS for services, and more recent expenditure data might be incomplete.)

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1				
FACTOR D:	46,791		FACTOR G:	145,147
FACTOR D':	10,610		FACTOR G':	2,147
TOTAL:	57,401	≤	TOTAL:	147,294
YEAR 2				
FACTOR D:	46,824		FACTOR G:	145,416
FACTOR D':	10,610		FACTOR G':	2,147
TOTAL:	57,434	≤	TOTAL:	147,563
YEAR 3				
FACTOR D:	46,952		FACTOR G:	145,604
FACTOR D':	10,610		FACTOR G':	2,147
TOTAL:	57,562	≤	TOTAL:	147,751